T H E

7TH ANNUAL RURAL HEALTH CONFERENCE

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T H E M E

"Community Action the KEY to Rural Health's Door"

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Sponsored by:
The Medical Society of the State of North Carolina

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Sir Walter Hotel--Raleigh, N. C.
Virginia Dare Ball Room
September 29, 1954

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Those of you who were in attendance know the successful outcome of this year's Rural Health Conference, with a record attendance of approximately 450. Two general statements were made which you will appreciate. (1) The program was complimented for being practical, informative, and stimulating, with accent on starting and stopping on time, and the ease with which the entire program moved and the atmosphere created by program participants. (2) Each person on program was singled out by someone as giving them the main high-light of the day. This proves the diversity of interest represented and the value of a multi-topic program. Two general criticisms are justified. (1) Need for a larger meeting place, and (2) better method of registration. These two problems should be considered in planning the 1955 conference.

As best as could be interpreted from the registration sheets, the following breakdown was made:

Physicians 28
Extension Agents 52
State College Extension Staff 15
Home Demonstration club members 118
Community leaders 57
Public Health workers 26
Farm Bureau 15
Schools 13
Medical Auxiliary 11
Dentists 9
Students 9
Grange 8
P.T.A. 8
Nurses 6
Ruritan 6
Newspapers 5
Dairy Council 3
Hospital Care 3
Hospital Savings 3
Rural Sociology Staff 4
Headquarters Staff 5
Special visitors 4
Department of Conservation & Dev. 2
Progressive Farmer 2
School Health 2
Mental Hygiene 2
T. B. Association 2
Ministers 2
Federation of Women's Clubs 2
Pharmacists 2
Red Cross 2
Department of Welfare 2
Dairy Products Association 1
State Bd. of Nurse Examiners 1
Carolina Farmer 1
Heart Association 1
Cancer Society 1
Council of Churches 1
Farmers Federation Corp. 1
Vetenarians 1
N.C.R.E.A. 1

Suggestions for next year's Conference program:

Community Health
Dental Health
Physical Health
Accident Prevention
Mental Health
Social Health
Nutrition
Audience Participation
Negroes on Program
Larger Meeting Place
Revision of small discussion groups
Shorter day's program
Use more lay leaders on program

In my community I plan to help promote the following:

Better sanitation
Physical examinations
Better personal habits
Better food habits
Recreation and social health
Preventive health education
Group planning for better health
Dental health
Securing a doctor
Accident prevention
Hospitalization
Red Cross home nursing
Mass x-ray
Immunizations

Some comments made in addition to evaluation sheets:

1. Each of the speeches gave me something to think about and look forward to.
2. Breadth of topics, calibre of papers.
3. Wide representation of attendance--good speakers.
4. This was a most informative type of program. I am glad to have the privilege of attending.
5. The program was well thought through in sequence - past, present, plan for the future, and how to accomplish goals.
6. Keeping program on time and the variety of subjects.

DR. HUBBARD: Ladies and Gentlemen, I want to welcome you to this important meeting and to express my gratification at the good attendance. I want to assure you also that it's a great privilege and a pleasure, and a great opportunity on the part of the Rural Health Committee of the Medical Society of the State of North Carolina to meet with you and to work towards one common goal, along with the agricultural, civic, health, and religious groups of the state. That goal, as you know, is better health for North Carolina. It seems that rural health has lagged a little bit during the past twenty-five years, according to statistics, and I hope we can do a lot here today to stimulate interest to the end that we may lift the rural health factor again.

At this point, I want to introduce some guests who are out of state, some very important guests, with whose presence we are honored today. First is Dr. F. S. Crockett. Dr. Crockett is Chairman of the Rural Health Council of the American Medical Association.

Mrs. Arline Hibbard is Secretary to the Rural Health Council of the American Medical Association. Next, is Mr. Aubrey Gates. Mr. Gates is an old friend of ours. He has been with us on several committee meetings and conferences. He is a great worker in the field of rural health. We are glad to have all of these folks with us. We also have with us our friend and co-worker, the President of the State Medical Society, Dr. Zack Owens.

At this point, I am going to turn the meeting over the the chairman of this conference, who will speak to you and make a statement on the purposes of the Rural Health Conference. It gives me pleasure to present Dr. Rachel Davis. Dr. Davis is a cheerful, consistant and effective worker with the Rural Health Committee in North Carolina, and it gives me great pleasure to present her.

DR. DAVIS: Thank you. It's with genuine pleasure and genuine anticipation, and the feeling of great responsibility that we meet together for this Seventh

Annual Rural Health Conference, which is put on and organized - and effectively put on, we hope - with the collaboration of the Medical Society and agricultural and public health and other agencies of the state, and I believe there are a one hundred twenty one listed who are interested in this problem of rural health in North Carolina. We failed to say to you the purpose of the Seventh Annual North Carolina Rural Health Conference. There are some of you who have not before been seen at these conferences and to you we give a very special welcome. I also recognize many of you who are annual attenders. This is flattering and it gives us strength and spirit to go on, and it indicates that maybe what we are doing has "meat" in it. For the newcomers let's define the rural health movement. It's origin, it's progress up to this point, and then state the purpose of the meeting. Since the settling of this great country of ours, there has always been a feeling on the part of rural folk and leaders that there has not been a favorable or equitable distribution of health opportunities and facilities to those who chose to dwell in the more rural parts of our land. There has been a general shortage of medical practitioners, hospitals, nurses and public health facilities in a great percentage of our rural areas. There has been a lack of knowledge on the part of our rural dwellers as to how to best use the percentages available, plus the lack of knowledge or the desire to procure, for themselves, those agencies and facilities needed most but not available. During the Second World War from 1939 to 1945, these conditions were emphasized by the depletion of the medical personnel and the re-routing of facilities for military purposes. In 1945 the A.M.A. and the great rural United States were fully conscious of their problems as were all other associated agencies interested in the health and welfare of this great nation of ours. In 1945, aroused by the real need for better rural health, a great lady, Mrs. Charles W. Sewell, who was then the Administrative Director of the Associated Farm Women of the American Farm Bureau

Federation, called at the La Fayette, Indiana home of our distinguished guest here, Dr. F. S. Crockett, and in that home that day the National Rural Health Program was born. Dr. Crockett presented Mrs. Sewell's and his ideas at the next meeting of the Board of Trustees of the American Medical Association, and Dr. Crockett became chairman of the committee to work on the problem. After much study and planning the proper idea evolved of combining the efforts of the American Medical Association with other interested health, social, educational, and agricultural agencies, and for these agencies to cooperatively support and participate at state and national levels in national rural conferences designed to help rural folk to help themselves to better health. Conferences like this one today has had this purpose. In today's conference we wish to sketch the progress in health over the last fifty years to find out how we have obtained our health status and to find out why we haven't obtained a better status. Then we wish to familiarize you with the many health and agricultural, social, mental hygiene, and sociological facilities which are ours for the asking, and ours for the use, and are offered to us by the agencies and the state of North Carolina. Then we wish to tell you something of the plan for continued improvement of the rural health in our great state. North Carolina has a remarkable program of health education to offer its citizen, just as quickly as its means of audio-visual education is profected and set to work. Then after those whom we know as authorities and specialists have spoken, we are going to hear from many of you as to how you have solved your rural health problems and we are going to attempt to help others to get ideas as to how to solve theirs. This is a conference for the projection of facts, an exchange of ideas plus ways and means which we hope that we will take home with us to solve our own rural health problems, whether they be ones of distribution, education, or budgeting or good farm practices, or just good living with our fellow citizens, each genuinely interested in the health and welfare of the other.

Thank you, Mr. Chairman and guests. It is now my delightful privilege to welcome to North Carolina, and to present to you one of America's great citizens, Dr. F. S. Crockett of La Fayette, Indiana, the co-founder of and the councilor on Rural Health of the American Medical Association. Two years ago, it was my privilege to pin an orchid on your co-worker, Mrs. Sewell. Today, Dr. Crockett, we bestow upon you our gratitude, our esteem, and our love. Ladies and gentlemen, I present to you Dr. F. S. Crockett.

DR. CROCKETT: Thank you, Dr. Davis, for a most gracious and generous introduction. Two or three years ago I was here in this same room at a meeting of your conference on rural health, and I watched the growth of this movement here in North Carolina, this being the seventh one. It is a great pleasure and inspiration to us who are attempting to carry on and do pioneer work to see what is done in the states. Work is going on in very many of the states in the union along this line and North Carolina is doing one of the good jobs. We are glad to come over and see what you are doing and how you are doing it, so that we can carry it back and use it elsewhere wherever it seems appropriate. The real purpose of this sort of a thing is team work. There was a time when you looked upon the medical profession as the people who kept you and made you healthy. The medical profession does have something to do about it. That's true enough. But the big point is that you are responsible for your own health, and if we doctors and nurses and other people who are in the medical business can help you to understand how to keep well yourself, you won't need to have all the expense of getting well, and you will get along with a lot fewer doctors. ALL desirable things. In other words, it's team work. You are one of a team and part of your job is to work with us doctors as it is for us doctors to work with you. It is a pleasure to me to bring to you the greetings of the American Medical Association's Council on Rural Health of which I have the honor of being the chairman. We were anxious

to come here, be with you, see how you conducted your meetings, see what you had to say, and to watch you in your work here because we do know that we have much to learn. Thank you very much.

DR. DAVIS: Thank you, Dr. Crockett. It is always good to know that we have the cooperation and the support of the American Medical Association, and I might say that they keep a very active office and anytime any community has a problem, if you will appeal it to your local County Medical Society, they will in turn appeal it to their state and then to their national socity, and maybe we can help you answer your problems on that level. Our next speaker this morning is a gentleman who has contributed much to the welfare of North Carolina - Mr. Harry Caldwell, Master of the State Grange from Greensboro, North Carolina. I have a very interesting biographical sketch here, I think most of you know it, but it is interesting and I am going to take a few minutes to read it. Mr. Harry B. Caldwell Master of State Grange, Greensboro, North Carolina. Named the Man of the Year in North Carolina agriculture by the Progressive Farmer. He is very active in health affairs in the state and served as Executive Secretary of the North Carolina Good Health Association 1946 and 1947. He is currently Public Director of Hospital Savings Association. Mr. Caldwell has gained national and state recognition by his contribution to national farm organizations, cooperatives, education and various foundation organizations. Thrcugh his leadership, the State Grange is aware of the importance of good health, to good farming and rural living and he has helped with better rural health practices throughout the localle in which he lives, the state and in national leadership activities. Mr. Caldwell.

MR. CALDWELL: The subject that has been assigned to me is "How We Have Gained Better Health in North Carolina." That is a very interesting subject. It involves a backward look, perhaps some of our past records and some of our past objectives and some of our past achievements. I think after all we have gained

better health in North Carolina as our people became concerned about their health conditions. About the conditions of our people, from the standpoint of health, and as we establish research to analyze the problems and to develop the program and the techniques, and as we worked out the plans and the programs, and as our people worked together in achieving the desired objectives. They are the ways in which we achieved better health in North Carolina. As I looked over the record, I was impressed with the many outstanding achievements in the field of public health. I would like for Dr. John A. Ferrell, the head of our Medical Care Commission, to stand up and take a bow, because I think perhaps he has served in the cause and in the program of public health in North Carolina longer than any other person in this audience. I noticed that he was Assistant Secretary of the State Department of Health back in 1910 and he was in charge of hookworm eradication, which was the rural sanitation problem of that day. Stand up, Dr. Ferrell, I think they would all like to recognize you. He is still one of our leaders and our workers in the field of public health. As I said a moment ago, we have achieved better health in North Carolina as people have become concerned about health conditions. Going back over the records, I note that Dr. Thomas F. Wood, a physician in Wilmington, became very much concerned over health conditions in North Carolina, along in the early 1870's. He wrote a number of articles in the medical journals of that day. As a result of his concern and the influence of his work, and his efforts the Legislature of North Carolina, in 1877, established the State Board of Health and appropriated the grand sum of $100.00 to carry on its program for a period of twelve months. It is right interesting to go back and read that history and see the progress that we have made in terms of public health service. In was in 1885 that the legislature became more interested in the program of public health and increased the appropriation to the sum of $2,000 for the year and it was not until 1907 that the Legislature ever

appropriated more than $2,000 a year for the support of our public health services. In 1900 the Board of Agriculture agreed to examine the water samples for the State Board of Health, so you can see that working relationship beginning as early as 1900 between the North Carolina Board of Agriculture which is part of the State Department of Agriculture and the newly created North Carolina Department of Public Health and down through the years there has been a spirit of cooperation between the agricultural agencies and the health agencies in trying to improve the health agencies, not only in rural areas, but through the state of North Carolina. Even today we find our Pure Food and Drug Program and other programs are interlocked between agricultural departments and between public services so that there is that working together now. In looking further in that record, I found that in 1907, the state appropriated $4,000 and in 1911 the General Assembly of North Carolina established the county boards of health to take the place of the County Sanitary Commissions that had been previously established here in North Carolina. Of course, the program of public health has broadened and expanded to meet the needs of North Carolina. This concern for the welfare of the people, this constant analysis and examination of the problem, the development of the diseases and epidemics have all played their part in helping the people in North Carolina to recognize the needs and to work together for legislative appropriations and in other ways to fulfill those needs, so down through the years the state of North Carolina has gradually broadened and expanded the program of public health and until today the state is appropriating more than two million dollars per year to carry on the program of public health here in North Carolina, but even then, health conditions are not all that some people thought they should be here in North Carolina, so in 1944, under the leadership of the late Governor J. Melvin Broughton, a commission was established to study the hospital and medical care needs of our people. Dr. Clarence Poe,

one of the imminant leaders of our day and generation, was named chairman of that commission, and that commission came to be known as the Poe Commission. Many distinguished North Carolinians served as members of that commission. Now when they dug into the problems and studied the general situation that existed from the standpoint of health services here in the state, they found a great many shocking things, of course the state and its people had gone through changes, not only improvements in terms of public health services, but as a whole there had been many technological changes even in the field of medical practices. The use of the hospitals had become a more important tool now in diagnosing diseases and in developing methods of treatment for those diseases. And there had been tremendous changes in this whole medical field as a result of research and as a result of the technological improvements that had come along throughout our entire society and so the Poe Commission, appointed in 1944, made a very thorough and systematic examination of health problems here in the state and they found many shocking conditions. I shall not burden you here this morning by reciting the conditions they found. North Carolina ranked low among all the states in the nation in the number of hospital beds per person now per thousand people. We rank low among all the states of the nation in available medical personnel and that included doctors, nurses, and technicians. We ranked low among other states in terms of use of prepaid Blue Cross hospital insurance plans and methods, and, of course, they found that health conditions were not good, certainly reflecting the lack of these facilities for use by the people of North Carolina. The Selective Service System found that more than fifty six per cent of our North Carolina boys were rejected from miliary duty as being physically and mentally unfit. That was a shocking situation and it pointed up the importance of a health program here in North Carolina, along with these findings by Selective Service, the record of rejects among boys of the orphanages

certainly emphasized that something could be done about it because less than 2% of the boys called up for military service from the orphanages of North Carolina were found to be unfit for military duty, but yet in the population as a whole more than 50% of the boys were found to be unfit for military duty. So the study made by the Poe Commission as a result of the concern by the governor and the concern expressed by various groups and organizations and the concern expressed by leaders in the medical profession itself, the Poe Commission made the study, conducted the research, and as a result of that research, found the truth about the need for an expanded program in the field of health services here in the state and the Poe Commission made its report on October 11, 1934, and said that there were three basic needs here in North Carolina - more hospitals, more doctors, and more insurance. They were the three great areas of need that were found to exist - more doctors, more hospitals, more insurance. I said a moment ago that we North Carolinians had less doctors available per thousand of people than existed in more than half of the states of the nation, and the Poe Commission found that as recently as 1940 that we had one doctor per 3613 persons in the rural areas of North Carolina, whereas the medical profession has said that the minimum number required to maintain a good health program is one doctor for each 1,000 persons. By 1944 this situation had even become more acute because they found that we had only one doctor for each 5,174 people in the rural areas, in the rural counties of North Carolina. And when you stop to consider that North Carolina is a great rural state, and only one third of our people live in cities and towns, and another one third in small villages, one third of the people actually live in the country, and the majority of our counties are rural counties and you can begin to get some idea of the great problem that existed in the rural sections over North Carolina. They were some of the situations that were found to exist. And then there was a great shortage of hospital beds in North Carolina.

I believe we ranked 37 among all the states of the nation in number of hospital beds available for use and 39 among all states of the nation on the use of the available hospital beds by the citizens of the state, and as a result of that, the infant mortality rate was extremely high, the average life span of people in North Carolina was lower than might possibly otherwise have been, and there were certain other conditions found to exist as a direct result of our failure to provide an adequate program, an adequate medical program here in the state. Well, you know this situation resulted in other actions, normally we would expect a chain of reaction to follow. In 1945 the legislature of North Carolina passed the enabling legislation and created the North Carolina Medical Care Commission of which Dr. John A. Ferrell is the Administrative Director and the Medical Care Commission then made a thorough examination of the situation in the state, they canvassed the ability of the people of North Carolina to do something about it. In the meantime the Congress of the United States had become interested in this general program, thanks to Dr. Crockett, and rural leaders who joined with him in creating a friendly atmosphere among the members of Congress before federal appropriations became available so this newly created medical care commission began to survey the prospects, the possibilities of doing something to better the health conditions among the people of the state and they came up with a program and recommendations and in order to implement that program the people of North Carolina themselves took positive action. Soon after the Legislature had adopted its program in March of 1946, a small group of public spirited citizens representing a wide variety of organizations and groups from all sections of North Carolina met together in Thomasville and incorporated the North Carolina Good Health Association and the prime purpose of that association was to disseminate the information about our health needs and to point up the ways and means by which the health conditions could be improved in North Carolina and solicit and

secure the cooperative support of the people in North Carolina in doing something about it. Many organizations, I shall not attempt to call the list of those organizations, as many organizations were represented among the incorporators of the North Carolina Good Health Association and that occured on March 14, 1946 and then the North Carolina Good Health Association established a promotional program,you are generally familiar with that campaign, I presume that most of the people in this audience today are old enough to remember the good health campaign promoted by the North Carolina Good Health Association. The Good Health Association organized a very intensive campaign of education - headquarters were opened, funds were raised from public spirited citizens, and a program was inaugurated. Mr. Kay Kyser, one of our outstanding North Carolinians who had achieved fame in the field of motion pictures became interested in the campaign and the needs of the people, came back to North Carolina and helped to organize the promotional phase of that work. Radio and newspapers, bill boards, and school essays, and so on and so on were in terms devices used in promoting this program for better health here in the state. We had films fixed, why they even had a very famous song writer write a song "It's All Up To You." If I were a singer, I might attempt to sing that little song for you this morning, but since I can't do that, Dr. Davis, I will spare the audience of that kind of punishment, but every media of publicity was employed and utilized by the people of North Carolina under the leadership of the North Carolina Good Health Association, but the space in the newspapers was given free of charge, the North Carolina Medical Society played a leading role both in the developing of the program and in working out the details of the plans and in prosecuting the program through to its completion. The Nurses Association, the Hospital Association, the Board of Health and all of its agencies, the health educators, and so on, the Labor Organizations, the farm organizations, the women's clubs, the American Legion,

and the various religious denominations of North Carolina, I have a booklet over here in my possession which contains a list of the various groups and organizations that endorsed that good health program here in the state and as a result of that great campaign of education which grew out of first concern, second research to find out just what the conditions are and the needs for action, the third, the development of a plan by the Medical Care Commission and then this promotional program which developed and brought together the cooperative support of the people of North Carolina. As a result of that great campaign the legislature of North Carolina adopted the Medical Care Commission Plan and appropriated money to carry out the objectives that had been established. Basically, the original program calls for an appropriation by the state to cover about one third of the estimated cost of building or providing 4600 additional hospital beds here in the state. It provided for an appropriation to construct a 400-bed teaching hospital and the establishment of a four-year medical school at the University of North Carolina. That was the basic provision of that program in addition the state appropriated money and created a loan fund to help young medical students, from rural areas acquire medical education with an understanding that those who used the services of that loan fund would return to a rural area or to a rural county to practice medicine for a specified period of time. That program was later brought to include loans for nurses and other medical personnel and there were other provisions included in the program. As a result of that interest on the part of the people and as a result of the support given to the program of better health by both the Federal government and by the State government and by our localities, North Carolina has gone forward and made real progress and since that program was established 43 new hospitals have been constructed in North Carolina, 41 hospitals have been enlarged, 53 health centers have been added to the state; a total of 75 million dollars of funds have been

spent in the development of this great program. There are about 13 counties respresenting three or four percent of the people of North Carolina, without any type of medical facilities, that is hospital or health center facility. Out of this 75 million dollars that have been spent, the Good Health Program of the State of North Carolina itself has appropriated roughly 16,000,000 dollars; the Federal Government, 25 million dollars; and the local communities, around 30 million dollars, in constructing these facilities. The four-year medical school has been enlarged, the two-year medical school has been expanded to a four-year medical school, so that today we have three great medical schools - the Duke Medical School, the Bowman Gray School of Medicine, and the Medical School at the University of North Carolina, and the 400-bed teaching hospital has been provided and the program is being expanded and developed to train the nurses and technicians and the other personnel needed in the operation of this expanded program in the field of public health. The state at present is appropriating about 115,000 dollars a year to administer this hospital construction program carried on by the Medical Care Commission. The state appropriates money to help the indigents and in addition, we have made great progress in expanding the use of the Blue Cross Hospital Insurance Plan among the citizens of North Carolina. Again I would remind you that North Carolina has achieved good health, or has achieved the objectives so far achieved in good health, as the result of the concern by our people, a desire to have good health, a concern about the health conditions that are bound to exist in many areas, then we have achieved our goals through as we have conducted research and developed and acquired information about the problem and developed plans and as we have worked together for the achievements of these goals.

It has been a real pleasure to be here and to have this opportunity to give you this brief look at some of the things that have been done in North Carolina

over the past 80 years in trying to improve health conditions for the people of this state.

DR. DAVIS: Thank you, Mr. Caldwell. That was indeed a very comprehensive review of how we have gotten to our status of present day health in North Carolina.

FROM AUDIENCE: In connection with his reference to student loan program, I might add that the fund was greatly increased by the 1953 Legislature and loans are now being made to students of medicine, denistry, pharmacy and nurses all of whom are permitted to at least four years professional services in rural communities defined as a community having 2500 population or less. Between 90 and 100 loans have been made to personnel of that sort already and the program is rapidly increasing in popularity. I would like to supplement, if I may, one statement made by Mr. Caldwell. Professional education is extremely costly and most of these students finish their courses in debt or certainly without capitol in which to establish offices and equipment. The recent 83rd Congress made an appropriation to aid isolated rural communities in the development of diagnostic and treatment centers for ambulatory patients. They may be established and operated at some distances from the hospital or they may be established independently, but they must be under the medical supervision and it is a pleasure to announce that there is now available in North Carolina a sum of money that will pay in least federal funds up to 50% of cost of diagnostic and treatment center which I judge will be somewhat similar in size and cost of the smaller health centers, 53 of which have already been provided and being used by the county health department. The Medical Care Commission to further this movement has created a special committee headed by Dr. Brewer who is on your program, and anything that can be done to work with people of isolated rural communities now without professional medical services will have an opportunity by virture of this new appropriation which is made available to the Medical Care Commission.

DR. MASSEY: I would like to direct a question to Dr. Ferrell, as to how many students of medicine, denistry, nursing and pharmacy have used the availability of these funds that are available for student funds. Do you know these figures?

DR. FERRELL: I think it is 93 to 96.

DR. DAVIS: I would like to ask a question, Dr. Ferrell. Are those funds exhausted or are they used up to the limit; are they being taken full advantage of?

DR. FERRELL: There are some funds still available for the remainder of this biennial period.

FROM AUDIENCE: For the people in the rural areas that cannot obtain funds to obtain Blue Cross Hospitalization, is there anything available to them if they need it, in case of hospitalization, of course you have outlined the program of diagnostic treatment and out patient treatment for the medical centers, but what about in-patient treatment?

DR. DAVIS: For people below the Blue Cross Insurance level, would that not come under the Department of Public Welfare? Mr. Caldwell, would you like to answer that.

MR. CALDWELL: I think that the answer to that question is that people who are below the Blue Cross level would look to the Department of Public Welfare and to, of course, some of the hospitals that have funds available for charity work. I think those are the two primary sources to help those in need of in-patient treatment below the Blue Cross level.

FROM AUDIENCE: Madame Chairman, I might add that in the medical indigent class, the State Department of Welfare can spend a dollar and a half, we hope it will be two dollars per day, toward the hospitalization of the medical indigent, the Duke Endowment contributes a dollar per day toward the hospital care and the Kate Bitting Reynolds Funds contribute somewhat less than a dollar a day, and it is expected that the county welfare department will make up the balance to provide

hospitalization for those who are certified as indigent.

DR. DAVIS: Does that answer your question?

FROM AUDIENCE: I'm in favor of rehabilitation for those medical indigent people who are physically handicapped and that applies to a lot of these people we are taking about. The Rehabilitation Agency pays the majority of hospital beds, including the doctors.

DR. DAVIS: Thank you. And Crippled Children's Bureau does the same thing. Does that answer your question? Is there another question? We thank you very much for this audience participation, this is indeed a good indication of the spirit and interest in this meeting. You have in your program an evaluation sheet. We want you to be critical of this conference and as the day goes along, make an evaluation, and when you leave fill in this sheet and give it to the hostess or mail it back to the North Carolina Medical Society at the Capital Club Building, Raleigh, North Carolina, and we will greatly appreciate this. This has a two-fold purpose; first, it helps us in preparing our future program and it helps us to strengthen our weak spots. We have two other distinguished guests with us - Dr. J. P. Rousseau of Winston-Salem, who is President-Elect of the State Medical Society, and Miss Ruth Current, who is head of the Home Demonstration Club work of the Extension Division. Glad to have you both.

DR. DAVIS: Now for our next speaker this morning. I've just met the delightful gentleman for the first time, and I read his biographical sketch and I have just told him he reminded me of Thomas Wilkes' story "Look Homeward Angel." It always gives me a great deal of warmth, when I see a son or daughter of North Carolina of great ability make a mark for themselves in the world in achieving educational opportunities and advantages, to return to their mother state to make their real life's contribution. That is what has happened in the light of Dr. Colvard, our Dean of Agriculture of North Carolina State College. Dr. Colvard is, as we have

just said a native North Carolinian and he is fully aware of the rural health conditions, being born and reared on a farm himself and most of his professional career has been spent with farm interests in the agricultural leadership. Most of it has been done in the State of North Carolina with additional training and experiences at Purdue University where he received his PhD degree in Agricultural Economics in 1950. He will speak on "Health in North Carolina Today." I present to you, Dean Colvard.

DEAN COLVARD: Thank you, Dr. Davis. The primary and most important resource we have in North Carolina is a very large number of people - the human resource. As Dr. Rupert Vance has pointed out, "All resources exist for man if he can but use them." In North Carolina we have more rural people than any state in the United States. It is their intelligence, their understanding of the forces of nature and the powers of science, and their physical efforts - labor - that determine how our other resources are used. As Vance points out, people are both means and ends.

It seems clear that our serious efforts must be devoted continuously to the improvement of the minds of our people through education, that we must constantly improve our scientific know-how in the use of our physical resources to provide economic returns and higher standards of living. This we attempt to do through research, demonstration, and other educational means. It seems equally clear that the health of our large body of rural people is of primary concern. It concerns not only our happiness but also our productivity. May I commend the leaders of this conference for their leadership in arranging it and the privilege of having some small part in the program.

Now at the outset I would like to examine very briefly the health status of rural North Carolina, it seems appropriate that we might do well to take note of some of the very great progress which has been made in recent years .

A. Infant Mortality. Dr. C. H. Hamilton, Head of our Rural Sociology Department, has recently summarized the infant mortality in our rural and urban people, both white and Negro, and the progress in reducing infant mortality among rural people since 1936 is most striking. Infant deaths per 1000 live births for urban white people were 74.8 in 1936 as contrasted to 53.9 for rural white people. This figure was reduced to about 26 per 1000 for both groups in 1952. Real progress in this area. In the case of Negroes, much progress has been made but the picture is not so bright. Infant death rates for urban Negroes were 132 per 1000 in 1936 as contrasted to 76 for rural Negro births. By 1952 both of these rates had been reduced to about 54, which is real progress again. The infant mortality rate for Negroes is still about twice that of the white race.

B. General Mortality rates in North Carolina are only slightly higher than for the nation as a whole. Great differences do exist, however, among sex, race, residence groups. Rural groups have lower mortality rates than urban people. From 1940 to 1950 mortality rates of urban people in North Carolina declined from 13.1 to 8.1. The white death rate declined from 10.0 to 7.6 and the non-white from 15.1 to 12.3 during the same period - that was from 1942 to 1950. North Carolina ranked 36th among the states in mortality rates in 1950. Tennessee, Kentucky, and Florida were the only southeastern states with lower rates. From 1940 to 1950 there was a decline in mortality rate for every county in North Carolina except one. Wayne County led with a 12.8 percent decline during this period. The lowest mortality rates, however, are found in our rural mountain counties. Clay County with an age-adjusted mortality rate of 5.1 per 1000 was the lowest and was followed closely by Graham,

Yancey, and other mountain counties. The highest mortality rate was Wilson County with 13.8 and Scotland with 13.7. But it seems to me that we do have there a clear picture of progress over years on both our infant mortality and our gross mortality.

C. Life Expectancy. Life expectancy of white North Carolina women increased from 59.3 years in 1925 to 73.1 in 1950; white men, 57.5 to 66.7 years; non-white women, from 46.9 to 63.2; and non-white men, from 47.6 to 58.7 years. Here again we see very substantial progress.

D. Certain diseases which were common a few years ago are almost unknown now. Yes, much progress in rural health has been experienced in recent years. For this all of us can be grateful.

E. Along with and as a contributor to this improvement has been the much greater consciousness of rural health as discussed by Mr. Caldwell, who has been a crusader in this field for many years.

F. While there are many natural advantages in rural living it should be kept in mind that certain "artificial" factors in the urban environment are more than offsetting the rural advantages. Infant and general mortality rates have been decreasing faster in the urban than in the rural areas.

Factors Responsible for These Improvements:

A. Improvements in sanitation knowledge and facilities. We need here to mention the great strides in cleaning up sources of infections for typhoid and similar diseases and the education of parents to the point that many health precautions are now routine matters.

B. One of the important improvements affecting the rural health picture is in the field of housing. Improvements in heating, cleanliness, bathroom facilities, lighting, water supply, and general sanitation obviously play a very important role in human health.

C. Increasing understanding of diets and nutrition and

D. Increasing quantity and quality of medical services, including Public Health Services, certainly are among the major factors relating to the improvements which I have mentioned.

E. Rural people have learned about these things through educational programs and have been motivated to greater use of these facilities and services.

So much for these recent trends and some of the factors which have been responsible for them,

Now, let us take a look at some of the ways in which the rural family and the rural community can work together for <u>further improvements in the future</u>. These <u>advances may be expected in the same areas</u> which I have already mentioned.

A. First let us examine the opportunities which seem to dramatize the improvement for better <u>sanitation</u>.

(1) <u>Family aspects</u> of sanitation can be greatly improved. In 1950 among North Carolina farm families the following percentages were without certain facilities:

Any kind of toilet	13.2%
Mechanical refrigeration	49.5
Kitchen sink	65.0
Piped water	67.9
Bath tub or shower	84.5

Here is plenty of room for improvement.

(2) There are at least three very obvious aspects which require community action:

(a) Cleanup campaigns and rodent control. The knowledge we have to apply now.

(b) Use of public health facilities in spraying and dusting for

insect control. And

(c) Water testing programs

B. Along with sanitation there is a very great opportunity for improvement in housing. Housing must be more widely recognized in relationship to morbidity (diseases) rate. Housing in rural areas is one of the major weak spots in our rural level of living. Rural family housing values must be raised and there must be increasing awareness of the relationship of housing and health. Farm families are not yet taking full advantage of educational sources of information on planning and remodeling.

C. Diets and Nutrition for all age groups can still be very greatly improved. Almost half of our 288,000 farms still do not have a milk cow and our per capita consumption of dairy products is only about half that of the national average. Here is one of the cheapest sources of good food. We have a very great educational job to do. The same general pattern prevails with respect to home gardens. We recently added a Home Garden Negro Extension Specialist with Nickels for Know-How Funds. The results of his efforts have been most encouraging. Both families and communities need to intensify their efforts along these lines. In some rural communities PTA's are studying the eating habits of their children. All of these efforts are commendable and need to be intensified.

D. Of course a major area in which we may expect great progress is in medical care services. Rural people go to a hospital less often than urban people. Low income families use medical care services less than the higher income groups. The rural family needs to be motivated and they must be able to purchase additional medical care services and especially preventive care. Great strides have been made in rural

North Carolina in providing hospitals and other health care facilities, but much remains to be done.

As we identify these areas in which progress in rural health may be expected, we should keep in mind that certain diseases are more prevalent in rural areas than in urban: I leave these to be corrected by doctors, but this much I know - typhoid fever, diphtheria, malaria, pellagra, pneumonia, and the like. These are communicable, dietary, insect carried, and generally low-level-of living diseases.

Major problems confronting us in our efforts to improve the health status of rural people are:

A. Low income

B. Distance to facilities, services, and personnel

C. Lack of education and motivation to really move out and take advantage of what is available.

As we look ahead to the solution of some of these problems we see the clear challenge to the farm family, the community, and to many professional groups. Through education the family must become aware of their needs.

The income problem is vital to the improvement of our status. I am happy to report that some progress is being made in this respect. From 1940 to 1953 the cash farm income in North Carolina increased 361 percent as contrasted to an increase of 284 percent for the nation. If we had only increased as fast as the rest of the nation our farmers would be receiving $154 million annually less than they are now receiving. By advancing our farm technologies through various means, including such voluntary programs as the Nickels-For-Know-How Program, to strengthen agricultural research, North Carolina has declared its intention to lift itself up by its own bootstraps and move forward a little faster than the average. We must continue to intensify our efforts to obtain higher incomes. This is to the advantage of all segments of the people.

Community action through community organization is playing and can play a major role in improving our rural health status. A recent study shows that in one county, Haywood, 80 percent of the rural families participating in the community development program had voluntary health insurance. Two-thirds of all the rural families studied in this county had some form of voluntary health insrance. Forty percent of the families having this insurance were motivated through the community development program. Notwithstanding this challenging example, the 24 counties in our state with over 60 percent rural population had only 7.4 percent of the population enrolled in Blue Cross in 1953 as contrasted to 26.4 percent for the 14 counties with less than 20 percent rural population.

If we can find a way through community organization to gear the resources of medical personnel, facilities, and services, organized public and private agencies, lay people and educational institutions to the job of improving rural health, we may expect to move forward considerably faster than average. The research and educational forces of North Carolina State College are happy to join hands with you in tackling these problems of better incomes, better bodies, and better living for farm people of our state. I thank you.

DR. DAVIS: Thank you, Dr. Colvard. That was indeed a very challenging message. We have done much, we have much to do, and we are going to have a discussion period and I am sure that Dr. Colvard will be glad to answer questions, which I know you all have, because every one of us in our own community have these problems on which he touched, and we want to know how to solve them.

We are proud of the representative group here this morning, not only in the great number, but in the interest shown. We have another distinguished guest, and this is a group of people who are giving this rural health program every cooperation possible and they give us an attentive ear and help us actively. That's the Dental Society of the State of North Carolina. Dr. Bernard Walker, President of

the State Dental Society is present. Will you please stand, Dr. Walker? Thank you. Now, we are open for a discussion period.

FROM THE AUDIENCE: Where do the Nickels-For-Know-How come from?

DR. COLVARD: Well, the Nickels-For-Know-How refers to this problem of attempting to improve the economic and living conditions of our farm people broadly, but more specially, this is a program which was envisioned by leading farm people and farm leaders in our state about three years ago, and the Legislature passed an enabling act, authorizing a referendum, giving the farm people an opportunity to vote, whether they would like to have a nickel per ton of the feed and fertilizer that one nickel per ton added to further the program of Know-how of agriculture research. There was about 90% plurality in endorsing this program and it has brought in an average of 30 to 50 cents per farm, of course, depending on size, or about $140,000 a year, or a little more, which had been used to add information through research and through extension work, such as the Nickels-For-Know-How horticulturist working with Negroes, to which I referred, has added about 38 positions, all together today, devoted to this problem of developing Know-How and getting its application toward the ultimate purpose of raising income. I should say that the third year is up; a new referendum is being held on October 15, and we have every reason to believe that the farm people are going to insist that this program go forward, but everyone should go out and express himself.

FROM THE AUDIENCE: You mentioned motivation of rural people. Would you tell me what is being done and various ways to get people to want to fit into this kind of farm activity?

DR. COLVARD: That's a good question. I will ask Dr. Horace Hamilton to give us his views on this first. I would say, at the outset, that one of the primary efforts of the organized forces in agriculture in recent years, has been to set up a set of basic objectives to direct the thinking of farm people to those

objectives and to assist in every way possible in helping them to organize their forces to achieve the objectives. That's been through the community development program and we are going to hear more about that through Mr. McGough this afternoon. In one area of the state, but we have some 85 counties in the state having some type of community development program, directed toward this whole principle of motivation and achievement. We have many other programs directed toward the same goal, but I think Dr. Hamilton, who is in charge of our Rural Sociology Department, and is quite a student of motivating forces in our rural areas, could comment on this, too.

DR. HAMILTON: Dr. Colvard, it would take a long time to even list all the agencies and institutions that have contributed to these motivating forces. I think the gentleman that asked the question - being a rural minister and having as his job that of motivating people to do good things; perhaps could answer these questions better than I could. Of course, all of our educational agencies are involved in this program of motivations in public schools. Public schools are doing an excellent job of motivating the young people and we hope that that goes back to the adult and then the 4-H clubs are doing a great job because their aim is: developing head, heart, hands, and health, and a very large part of that is not only health education, per se, but motivation of good health practices. I think this problem of motivation is something that grows by social pressure over a long period of time. It's coming to North Carolina, it's gathering speed and I don't think we need to be concerned about it's slowing down, with all these health education agencies putting out so much effort within the field. I think one thing that motivates people in communities to better health as to how, in their community, not only doctors and dentists and nurses, but also some sort of visable health institutions. We have such schools that symbolize these educational interest, and we have churches that symbolize the religious interest;

we have garages and filling stations that symbolize the transportation and the automobile industry make-up and I think there is no more important and tangible things to be one than to build more small diagnostic service and small clinics in the community itself.

DR. COLVARD: Miss Wilson, our foods and nutrition specialist is with us today, and I'd like to call on her for a comment, please?

MISS WILSON: Dr. Colvard, one of the ways in which I think all the agencies try to motivate people is turning to them the problem and helping them make decisions as to what they want, and what they want to do about them. We know from all education research that in order to get the job done, fifty per cent of it is done when people themselves have strived to do what they want to do. I think that is the biggest thing we are going to try to do in motivating people to improve health conditions.

DR. DAVIS: Thank you, Dr. Colvard and others, for this discussion. I do think that the problem of motivation is one of our greatest rural problems and I think that maybe we have lived with our problems so long that we don't realize they are problems, and it is good to have outside help to point them out to us and maybe that is one of the best motivating aids that we can have. Our next speaker is Dr. E. G. McGavran, Dean of the North Carolina School of Public Health, who will speak on "Working Together for Better Health Tomorrow." Dr. McGavran, since 1947 has been Dean of the School of Public Health, University of North Carolina, Chapel Hill. Before coming to Chapel Hill, he was Professor of Preventive Medicine at the University of Kansas Medical School and Washington University Medical School in St. Louis. Prior to that, Dr. McGavran was Health Commissioner of St. Louis County, Missouri, Morganton, West Virginia and Hillsdale, Michigan. He has conducted research studies in Egypt, Hawaii, and the Central American countries and he has done health surveys and studies in many cities and

counties throughout the United States. He is Chairman of the Board of Editors of Public Health Reports. He is vice-president of the Association of Schools of Public Health, and has served for several years upon the Governing Council of the Executive Board of the American Public Health Association. Dr. McGavran was in Europe serving as the United States Delegate to the World Health Conference from May until September, 1952, and subsequently studied public health problems throughout eight countries in Europe. Dr. McGavran.

DR. MCGAVRAN: Madam Chairman, Ladies and Gentlemen. My subject is "Working Together for Better Health Tomorrow", and I think the last speaker, indeed, all the speakers this morning, and the discussions have really made my speech for me, because they have been talking about this same subject and talking very effectively, giving you information which is essential to this particular topic; however, having had the honor of being asked to speak, I am going to go ahead and give you some of my ideas about the same subject as well.

The danger of that word "tomorrow" is dual. First, the danger of procrastination "why do today what you can put off until tomorrow" and "putting off" has been one of the cardinal and costly sins of good health. Second, there is the danger that tomorrow is an unknown and therefore crystal gazing, prognostication, and in a sense guess work. I should like to avoid both dangers or traps and present simply three or four experiences from which we can learn important lessons for the future.

First, I want to tell you about a community not far distant, that had some years ago a lot of cases and deaths from diphtheria. The good, intelligent people of this community had their children immunized against diphtheria but still the disease, diphtheria, was rampant and not only killed the unimmunized but also the children that had been immunized -- for no immunization is 100% effective -- 80% plus or minus of those immunized are partially protected but a massive exposure

or dose of the diphtheria bacilli can and does break through even those partially protected. The only real, sure protection for your children is to have the community immunity against diphtheria sufficiently high so that the disease cannot become established in the community --- only then does it disappear, only then are your children, the individual, really protected against diphtheria.

So this community passed a law that all children must be immunized against diphtheria before they entered school. This was done effectively and efficiently and still diphtheria cases and deaths occurred — not only in the unimmunized pre-school population, but also among the school children who had been immunized. It was finally determined that the school child age is too late a stage to start protection and so this community concentrated its immunization program upon infants under two years of age. This is a harder group to get at, you can't pass laws forcing infant immunization, but by dint of hard work they began to get their infants immunized. By the time that only 50% of all infants under two years were immunized, all diphtheria disappeared from this community — no more cases, no more deaths among those immunized and among those with no immunity.

Now, the lesson we learn from the common experience of this and many other communities is so obvious it's hardly necessary to state it. "Better health tomorrow" is going to be dependent upon our <u>focusing</u> upon community health rather than the individual's health — greater concern over our community's, our neighbor's health than our own — a strangely Christian philosophy, a truth taught us by "The Great Physician" almost two thousand years ago, and yet not generally practiced by most of us.

We should also recognize that the community is a very complex and difficult patient and that it will take highly trained and skilled people in community health to determine the epidemiological factors of importance to its health. In the simple matter of age, think of the <u>thousands of dollars</u> wasted for years by

our example community because they got the wrong age group to immunize. This can be multiplied thousands of times not only in dollars but in illness, suffering, and death that could have been prevented by properly, adequately trained and educated people in community health.

For my second example I want to take you back fifty years. In this country there were two great killers. One was typhoid fever, the other syphilis. Both were fearful, dread diseases---common killers with long illness and disability for those who did not die.

For one of these diseases, syphilis, medical science fifty years ago discovered the most accurate, simple diagnostic tests---not one, but many---easy, cheap, quick -- commonly known as blood tests. For the other, typhoid, the diagnosis is still difficult and time consuming---the tests uncertain except after repetition, with "clinical judgment" playing the important part.

Medical science fifty years ago not only discovered a perfect diagnostic tool for syphilis but it discovered a magic drug to cure the disease --- sodium silver salvarsan - 606--- later more magic drugs, the arsphenamines and penicilin. Typhoid, on the other hand, for the first fifty years of this century had no drugs to help in its cure. We depended on good nursing, supportive treatment, and the grace of God.

Here were two great diseases at the turn of the century. Syphilis, for which we had all the answers necessary for its diagnosis and cure; typhoid, for which we had no cure and poor diagnostic techniques and tools.

What happened to these two diseases in the communities of the United States in the first fifty years of this century, memorable in the lifetime of many of us? Typhoid has decreased so rapidly that a case today is heralded as wonderful teaching material for medical students. Most United States communities can boast of no cases or deaths in the past ten years.

Syphilis, infection syphilis, has continued to increase steadily from 1900 to 1950---steadily and substantially. Why?

Simply that syphilis, despite its magic cure and easy diagnosis was a disease which, because of its very nature, was considered and treated as a private and individual disease---early diagnosis and treatment of the case; while typhoid has been approached as a community disease---a community problem---improved sanitation, purification of water, and protection of food.

It is questionable and unlikely that immunization against typhoid has had much to do with the dramatic and almost complete conquest of this disease.

The lesson here is again obvious and not limited to typhoid. Malaria, hookworm, and yellow fever, all common sources of illness, death, and debility fifty years ago, have been practically eliminated by approaching them as community health problems---working together not for our own benefit but for the benefit of others, of all the community.

Today our great diseases and killers are heart disease, cancer, accidents, mental disease. How are we attacking these problems. Like we did syphilis or like we did typhoid? You know the answer---millions of dollars for the "individual" approach---pennies for the community approach. It takes no crystal gazing to prognosticate that we will only conquer the leading causes of death in the United States and North Carolina as we work together upon ridding communities of heart disease and cancer and accidents; work together to make our communities healthier places, both physically and mentally----prevention rather than cure---emphasizing prevention in communities rather than prevention in individuals.

This does not happen by good intentions. They say "hell is paved with good intentions." It happens only when we are prepared to put our money, our tax money, on the right horse. Working together, working hard together, for this change---not just talking together.

My third example comes from an experience in the Hawaiian Islands. For a great many years the infant diarrhea and dysentery rates among the workers in the sugar cane fields of the great sugar plantations were very high indeed, causing much illness and death. The plantation owners spent a lot of money in establishing good hospitals and medical care for these people, improving sanitation and health education, and still the rates were high for this group of diesases. Then someone, by accident, made available to the workers artificial refrigeration. Every house I visited, however poor, some I saw with no furniture, no tables or chairs, but all had beautiful new refrigerators that anyone of us would be proud to have in our home—and the dysentery and infant diarrhea disappeared. Beyond a question of doubt---refrigeration did more for preventing infant diarrhea and dysentery than all the health services had been able to do previously.

Now, the lesson we learn from this experience is that good health is not a simple matter of hospitals, medical care, dental care, or sanitation, or health education---fine and essential as these may be. But better health tomorrow is intimately related to many other health sciences and conditions---better agriculture---better nutrition---better economics---better housing---better communication---better roads. The health sciences cannot alone "work together" for better health tomorrow. They need the sophisticated skills of the economist, the sociologist, the anthropologist, the political scientist, the agriculturist upon a team of democratic equals to work for better health tomorrow. This cooperation is happening in our universities but happening very slowly. It must happen in our communities as well. No individual and no individual profession has a corner upon the neceseary skills and knowledges that are essential for better health tomorrow. We must work together---not as slave and master, not as horse and driver, but upon a parity, with mutual respect and understanding for one another.

Work together for more concern and more money for prevention.

Work together for more concern about community health than individual health.

Work together for more concern for our neighbor's health than our own.

Work together for more concern over better trained people in community health.

Work together for more concern for the changing emphasis in a rapidly changing world.

Working together is not just a catch phrase----like the terms coordination and integration have become. It still has the simple force of action. It means sweating it out together, physical as well as mental effort, something hard and honorable with untold promise of happiness and healthiness unknown today.

Now in vain the distance becomes
Onward, onward let us range
Let the great world spin forever
Down the ringing grooves of change.

DR. DAVIS: Thank you, Dr. McGavran. That was another quite thought provoking, comphrehensive anaylsis of the need for working together for health for everyone, not only for rural health but to raise the health index of the nation. Who will be the first to ask Dr. McGavran a question? All right, Mr. Harry B. Caldwell.

MR. CALDWELL: Dr. McGavran, you have given us much food for thought. It occurs to me that all the organizations are going to have to accept greater responsibilities. We are living in a day when people will agree with us that community action is necessary, but how are we going to get them to join with us in carrying forward that program?

DR. MCGAVRAN: Well, I think that is the sixty-four dollar question all right ,

and if we knew the answer on how to get all the communities to work together, we would be much wiser than we are. I think this thing is important, however, for us to recognize in working on the problem that we are working with communities as separate and independent units. Now, when we decide that we are going to work together with a neighbor or with a friend, or with anybody else, we don't approach that individual in exactly the same fashion that we approach another individual, because we recognize that each person is a separate person and I think that one of the mistakes that we make in approaching communities is that, we assume that because they are communities, that they are going to all be alike. Every community is just as different from the next community as every person is different from his neighbor, and this demands a tremendous amount of skill and knowledge concerning communities and the way communities function and how they work, their power structure, how people get together in communities, and their social structure, and their religious structure. All these factors that determine how a community is going to work or how it is going to work together or whether it can work together, and since these skills and knowledges with the social scientists, the behavoral scientists have developed a great many techniques in the last few years and most of us are pretty well handicapped, because we haven't absorbed those techniques yet, we haven't even heard about many of them, and we need to turn to these people who have made studies of this sort and get their sophisticated skills and knowledges so that we can approach communities as individuals rather than as groups, and I think when we begin to approach a community as an entity, as a separate entity, we will begin to get that kind of reaction. Now I have only one thing that I would add to this, and this, of course, I am sure my faculty would object to strenously, if they knew I was going to drag the body politic into this occassion. I like to use the term for a community (body politic). It's a good old term that goes way back to the Mayflower Covenent,

even though it may sound a bit new. It is a term which helps us recognize that a community is an entity just like any other entity.

DR. DAVIS: I would now like to call on other guest speakers for what comments they would like to make before the close of the morning session. Mr. Caldwell, would you like to add something?

MR. CALDWELL: The objective of pulling us all together into a cohesive unit, so that together, we can take a look at the future, so together we can develop our objectives and our plans, together we can outline a procedure that might be followed in getting the thing done, and together we might carry on the program of education, program of promotion and support that is necessary to generate this interest that will, in turn, bring these things about. I think that is very important. The second one that I mentioned, I think we must continue to support the state appropriation for medical care, enlarge appropriations in some instances. There are thirteen counties still without even a medical center or health center. Rural communities in North Carolina are yet without doctors and medical personnel and we have an unfinished task and I think it would be unwise for us to assume that the state of North Carolina can now withdraw from the field and curtail its financial support for public health, for the construction of hospitals and medical centers, for the training of doctors and medical personnel and I believe that all of us need to give that program our wholehearted support. These are two basic things that occurred to me in addition to those that were suggested by Dean Colvard in his remarks about building our economy and improving good nutritional practices and such of that nature.

DEAN COLVARD: Dr. Davis, I might just make one or two comments. I was particularly interested in Dean McGavran's statement concerning the use of the social science techniques as something specific, positive, and helpful in identifying these felt needs. We know from our experiences in organizational work that it

isn't enough for the heads of agencies, the leaders alone, to get together. We can set objectives, we can identify goals, but community action, I think we've learned rather clearly, is related to needs of people in the community and how those can be motivated is the real concern to us today. I would like to emphasize that we need to recognize the contribution which the social sciences as a science, with real techniques for bringing people together and understanding these problems of motivation, we need to understand the contribution they can make. I would say that probably if I tried to interpret to the general public of North Carolina each department in the School of Agriculture, that I would probably have as much difficulty making the Department of Rural Sociology an understood and appreciated group, as a concrete science, with a real contribution to make, as anyone and yet, as I study the work that is done and the techniques that are being developed, and can be developed in that area, I would endorse Dean McGavran's point of view, that the social sciences have a great role to play here, as we resolve these community actions to specific sciences and develop programs from them.

DR. WASHBURN: I've been interested in hearing Dr. McGavran talk about this and I wonder what effect the making of laws has had to do with it and what still further remains to be done in the matter of passing some laws through legislation. We think of ourselves as law abiding and yet there are probably some laws on the books that we are not obeying in regard to our health problems. What has been done and what could be done in just passing a few simple laws?

DR. MCGAVRAN: Well, of course, we always want to find an easy way out and we usually do this by passing laws and then we get into trouble on that. It seems to me that the problem isn't with our laws, but with ourselves, We have passed laws and set up our programs on the basis of how we will benefit and I think that we will gain a great advance in health tomorrow as we can get out of

ourselves and begin to think in terms of protecting the community. We ask the Legislature for more T. B. hospital beds, but do we ask for screening all admissions to general hospitals by x-ray? This would cost only a few thousand dollars and would do more to reduce the rates of tuberculosis in North Carolina than all the millions that we spend on hospital bills. We don't have to pass laws, they can just appropriate money to do some of this preventive work, but they don't do it, because we don't ask them to. I am more concerned with shaking ignorance and apathy, and I think the laws will take care of themselves when the American people wake up and decide to go after it.

MISS CURRENT: I would like to repeat what our friend has just said. Ignorance and apathy. I think that we have got to begin where we are with what we have in our community. The farm families in North Carolina have been wanting better roads and they are getting better roads today. We've been wanting telephones and we are getting telephones today, and I think that if we want hard enough and long enough to come together as people in the community and analyze our health problems that something will be done about it.

FROM THE AUDIENCE: It just occurred to me that we are here from communities all over the state, and I wonder if we could get Dr. Hubbard and also the President of our Dental Society, who is here, to come to the microphone and tell us about the diseases we need to be most conscious of, what they consider real important, so that we may go back home and do something about them. What about the dental situation?

DR. WALKER: This is really to me like a revival. It's really a spiritual uplifting and certainly gives us a great deal of food for thought. We in Denistry are certainly interested in the health of the people in our state. We are interested in good foods and we are interested in all departments of public health. Dr. McGavran's talk was really one that I endorse and was happy to hear.

Denistry is unable with the number of practitioners we have today to do all of the work that is necessary to be done, if it were done for each and every individual in the state of North Carolina. We are interested not only in preventions, we are interested in conservation. As those of you know that conservation, whether it be soil conservation or conservation of the health of the people, saves millions of dollars and it saves from a humanitarian standpoint - human suffering. We feel that way about dental caries, about decayed teeth. The suffering of children, the suffering of teenagers, adults, the results of infections from dental absesses and oral infections, certainly is a pitiful thing whether it be a child or an adult. Public Health is to be congratulated on the work done over the past fifty years. As Dr. McGavran said, we have private diseases and communicable diseases. Dental caries have often been treated too much as a private disease, and yet every child that goes to school or misses a day from school, or is inattentive due to suffering from dental caries is costing the tax payer money, and that is a loss, the loss of man power is always a loss, not only to the community but to the country. The Dental Society, the Medical Society and practically every society that is interested in the health and welfare of the American public has endorsed what we think is one of the greatest preventives that have come about in the dental profession or the dental field since denistry was started or since people paid attention to the human dentation, and that's flouridation of communal waters. We are interested in this and we are working for flouridation of communal waters for selfish reasons. If we were not, we certainly wouldn't have boosted.it. In the state of North Carolina there are communities that do have natural flourine and in those communities they have excellent dentation. Many of you may think, "Well, why is it that my teeth are good and my children's teeth are so poor? We see that they have the orange juice, we see that they have the milk?" But there are many of us who

have good teeth today. When we were children and raised in the rural areas, we had deep wells and they had flourine in the water, and that is where a lot of us have good teeth in spite of some of the strap molasses and fat back and corn bread we had, and some of the soda pops that we had at that time. Flourine in the water is like immunization and Dr. McGavran mentioned the fact that in spite of immunization they sometimes have epidemics and people and children who have been immunized do have diphtheria, so it is with the flouridation of the water, it is not 100 per cent but if it reduced it fifty to sixty per cent, which we have evidence that it does, we are for it. It is certainly a pleasure to be here and I wish for this organization, the Medical Society, to be congratulated for instituting this type of program.

DR. DAVIS: Any questions to Dr. Walker?

FROM THE AUDIENCE: In these rural communities we go to our private well for water. We do not have any community source of water where many of us come from. Now what can we do out there?

DR. WALKER: Well, if you can go down to the right depth and if you are fortunate enough to be able to have traces of minerals in your water, you are very fortunate. Now it can, of course, be added to drinking water, the cooking water, but, as if you are in a community where the water is contaminated you either have to dig another well, or that's why in thickly populated areas we have used means to kill off dysentery and other things that contaminate the water.

FROM THE AUDIENCE: Where can we get a simple printed formula for flouridation of water?

DR. WALKER: Dr. Ernest Branch, the Head of the Division of Oral Hygiene, is an authority on that and I'm just a practitioner and Dr. Branch is doing an excellent job and certainly is acquainted with those counties which he represents.

DR. DAVIS: Dr. Branch is in the audience, I believe, isn't he? Dr. Branch, could you answer if there is a bulletin available to people without city water supply as to how they could flouridate their water?

DR. BRANCH: As far as adding the flouride to the water, that which you are going to drink yourself or give to your child, right now it's not considered very practical. I have no doubt in my mind but what that can be worked out in an unusual case, but it seems to be more practical if you have small children, as many places in the state now are adding the flouride to the water. Do like we used to when I was a boy. Take a jug, go to the fathom spring and get some spring water and bring it home. Now we are traveling to and fro in the land all the time. It is an easy matter to put a five gallon bottle in the car and get the water that the small children are going to drink. It is necessary that these children have it during the formative period of these teeth, that's in the jaw under the gum. That's when it is going to do real good. Now still better, and more practical I think, is to have your dentist to apply it topically where you don't have it in your municiple water supply. But why not let's realize the real value of this thing and have our municipalities add it to the water. We have heard a lot said for and against it lately. There has been opposition to everything that is worthwhile. I've been in public health so long I remember, and so does Dr. Hubbard, and a good many of these folks - the opposition that we had in immunization against diphtheria, typhoid, and all those things. We have just got to live and learn and it takes a long time for us to learn.

DR. DAVIS: Thank you, Dr. Branch. Are there other questions concerning preventive dental care? If not, Dr. Hubbard, do you have any comments to make on the most vital health needs in North Carolina today?

DR. HUBBARD: I will say that it is one thing that has been brought out here today is to the effect that cooperative effort is important in all health measures.

Good health isn't the business of an individual alone anymore. It's everybody's business, and the medical profession doesn't have any corner on it at all. We realize that every organization, every group represented here has a vital health interest, naturally in improving health conditions, particularly rural health conditions. Our health means, as Dr. McGavran has pointed out, many things. Means not only medical treatments, it means more doctors, more nurses, more hospital beds, more churches, more schools, more roads, more automobiles, ambulances and a host of other things. And so those, of course, for that reason, to work together if we are to have better rural health conditions in North Carolina. In so many cases as I see it, it's a matter of education and that's why we have such a large group here this morning. People are getting more and more interested in it, they are going to pass this on as an educational move to individuals in the community, which I am sure will profit greatly by it. We must educate our people, not only to realize what they need in the local communities as I see it, but how they can get it and how they can go about getting it through help from the Medical Society, through help from the Home Demonstration Clubs, through Legislation or what have you. Mr. Hendricks asked something about the diseases of today compared with those of yesterday. The Medical profession feels that it has pretty well conquered acute infectious diseases of yesterday. This, of course, has come about through research, sanitation, hygiene, better nutrition, and a host of other things, so that we don't feel that we have to worry too much about acute infectious things anymore. We prevent them. You know, someone said recently that "to treat" was the voice of yesterday. To "prevent" is the divine whisper of today. That's what we are listening to, we have got our eye to the ground and we are trying to do more and more in the way of prevention of diseases. Yesterday, Dr. McGavran pointed out, we had the problem of typhoid, and I remember in late summer and early fall of the year

when it used to ravage in the communities I have seen them die by the dozens in different communities and in my community as a boy - syphilis and a host of things, acute infectious diseases, diphtheria and so on and so forth. You know about those. It seems that our main problem today,is, of course, the concern of finding out the cause of chronic diseases, things like cardiovascular diseases, diabetes, cancer, and I think we are going to have to approach that at the same angle we approached the cure and eradication of acute infectious diseases. That is from the standpoint of research,largely, and education. I would like to point out again - as you know the Medical Society of the State of North Carolina is vitally interested in helping you in your different communities with your individual and community problems and it must be of course on the community basis. For several years now since 1946, since the Rural Health Committee was organized, we've got a field representative or almost from the start we have gone out, done a lot of foot work trying to educate folks as to their needs. Talking to individuals, groups, civic groups, religious groups, agricultural groups, trying to find out what they needed most in the individual community - and they all differ, as Dr. McGavran pointed out - there is no community that has the same problems, and we tried to teach those folks, tried to show them how to find out what they need and how to correct it. We have a consultative service, as you all know, in the form of a health educational expert who is willing, ready at all times to go to any community, to any individual, any organization, to help with rural health problems. She will be glad to go. The Medical Society of the State of North Carolina will be honored to have her go and help you with any problems that might arise in connection with your health situation. Thank you.

DR. DAVIS: Thank you, Dr. Hubbard. I believe that we can say that as a result of presentations this morning, that health is a community problem not purchasable, not marketable, but to be brought about by better doing and active

cooperation by all of those generally interested each in the other in raising the health index of our whole state.

AFTERNOON SESSION:

REV. HENDRICK: At the afternoon session we are glad to have Dr. Arnold Hoffman back with us, Mrs. Hoffman accompanying him, and he will lead us now for these few minutes

(PERIOD OF SINGING)

REV. HENDRICKS: I would like the first four who are to appear on our program this afternoon to come forward please. Dr. Bruaer, Dr. Brewer, Mr. Andrews, and Mr. Andrews.

It is good to have you here. We have had a very broad representation from all over North Carolina for this conference today, and representing the areas of this state and representing the groups that are interested in the welfare of our people. We appreciate your presence, and we had a wonderful presentation this morning, looking at what has taken place across the years and then at our situation today with something of a look at the prospects for the years ahead. We certainly have had a background of perspective, now for the down-to-earth practical approach this afternoon.

We need to look at the past because it does have something to say to us. But we are interested now in going back to our own communities and doing what we can through community groups to get something done about our health situation, and we are here for the rest of the day to consider some of the situations that concern us all and to consider ways and means of doing something about our community problems back home.

Our first presentation this morning has to do with dental health, and I am asking Dr. L. M. Massey of Zebulon who is on our evaluation committee - and we

do want an evaluation from every person here - and I am asking him if he will say just a word to all of us about how to express yourself about this meeting and about next year's meeting, and then if he will present the one who is to speak to us about dental health in North Carolina. Dr. Massey.

DR. MASSEY: When I say to you that I want to introduce Dr. John Brauer, Dean of the School of Denistry of the University of North Carolina, that is sufficient, but when I say that this man has been the inspiration to the dental profession of North Carolina for the last four years working with the Dental Society, I can truly say that is true, but when a man measures up to being chosen as a dean of a new school who has turned out its first class this past spring and we are evaluating them as 100 per cent products, then we say enough about an introduction. Without further ado I should like to present to you, Dr. John C. Brauer, Dean of the School of Denistry of the University of North Carolina. Dr. Brauer.

DR. BRAUER: Thank you, Dr. Massey, Mr. Hendricks, ladies and gentlemen: I was tremendously impressed this morning with the message that was brought to all of us from speakers that were real statue in their respective fields and I am sure that if we could have left this noon that we could have gone home and our trip would have been worthwhile regardless of the number of miles that you and I might have traveled. So from my point of view the meeting has already been a success. This morning, particularly, I noted that the speakers emphasized from time to time the medical aspects of a general health program or a health program. This afternoon we will have not only the medical aspects but also another area that we cannot divorce from an acceptable general health program, and it relates to denistry. Now about 95 per cent of the people, perhaps 96 per cent of this audience have had one or more dental problems and if you haven't had one to date you will have one in all probability. So we have an almost universal topic from the time we have a child arise on the scene of this earth until the time

that he leaves and so I think we have a rather popular subject, an interesting one, and certainly an everyday one. So I would like to indicate that denistry certainly has its rightful and intended place in a total health program. We are interested in teeth, yes, very much interested. We are interested in dental caries, yes, we are extremely interested in that particular disease. Ninety-five per cent of the people do have dental caries, dental decay , if you please, but we have many other problems in denistry that I think that one might focus one's attention to. Charlie Mayo, from the Mayo Clinic, one time said that about 90 per cent of all infection is from the neck on up and then about 70 per cent of foreside infection is in and about the oral cavities. Then we are also extremely interested in growth and development. Growth and development, not only as a body as a whole, but of the head, face, teeth and so what. So we must be interested in nutrition, we must be interested in the things that promote growth, promote development, and in the life of growth and in the proper sequence of growth. We can or cannot have the very sorted out problems that somebody presented this morning. Then denistry is extremely interested today. It must be interested, if we are going to approach and attack the problem at all from an individual level, from a home level, and from a community or state and national level, as it relates to prevention. I don't like to talk about the last World war, but I had the privilege of actually seeing a great millions of men in action in terms of general health and dental health, and we found that one individual out of every two, that was during World War II, one individual out of every two didn't remember when he was in a dentist office last. We had one individual out of every four of military age level that needed emergency dental treatment, not just routine treatment, but emergency dental treatment, that means across America, Then we had one individual out of every five of military age level that needed one or more dentures, crutches if you please, yes, we could make beautiful dentures, but

there is no one that can make a denture quite like the good Lord made for us. But in either event, one individual out of every five needed one or more dentures and then for the real sad story that 12.2 per cent of all of our dental patients were twenty years and below. Now North Carolina has never had a dental school in this state prior to its activation in 1950 and the dentist of the state of North Carolina dug down in their own pockets and said something like this. "We would like to find out what the real problems of North Carolina are as related to denistry," and so they imported an individual and a staff to permit a state-wide survey. They found something like this. That in the state of North Carolina we have about one dentist to every 3700 people. The national average is about one to every 1800 people and then we have some states that have one to every 1100 people in the state. Now the armed forces require by law to have one dentist to every 500 men that we induct into service and so you can see the problem that we have in the state of North Carolina. We have a problem of prevention. The country over, in this entire United States, in the dental caries problem alone, just as one phase of denistry, we have a caries rate attack six times greater than we are filling teeth today. We're just simply interested in filling and restoring teeth and that is the loss that we actually exemplify in our everyday routine of trying to restore teeth and build teeth. So we are hopeless in our approach to the real dental problem. Yes, we will continue to restore teeth. We'll continue to make dentures. We're going to continue to be interested in all infections, but if you and I as an individual and as a family and as a community, are going to attack a problem, we must be interested in prevention. Now during World War II, we had millions of men living overseas in a state of emergency and needing emergency treatment, and finally in mid-August, 1943, we had to shut that particular overseas travel without benefit of having major treatments. And so in this country we spend months and months, trying to rehabilitate

and recondition individuals so they can go overseas and then I'd like to leave this very significant point with you. That if no time in the future of our history and as you and I can envision the rapidity with which one nation attacks another we will never have time to recondition or rehabilitate man either in medicine or in denistry such as we had in World War II. And so I am just interested in the national economy, the human economy, forgetting individual economy, forgetting community economy, just taking a look at this grand national problem of ours, national defense, you and I have no other alternative than to take a real look at prevention. One child out of every two at the age of three already has an attack of dental caries. Let's say that again, I think it is a powerful statement and one that you cannot deny, and that it is with us every day of the week, and that is that one child out of every two already has an attack of dental caries. And so if we are going to approach the problem, we must start with the pre-school child, we must start with the individual family at the time that child is born and even before that, in the terms of adequate nutrition, adequate care, and adequate follow-up, and then you know I have had some parents outside of this room who have said something like this, "You know, it's only a baby tooth, only a primary tooth, and we could take that one out and we would have some new ones growing there some day." That's right, but you know I have never found any reason why the Good Lord put a tooth in a child's mouth if he didn't have an intent of having it there and the reason is too for having them there is for adequate function, for adequate growth, and development of the face, etc., and adequate mastication of food and you can't by-pass it regardless of what your total health problem is. And so, the moment we have to take out a tooth, and we do many, many times at the age of two and at the age of three and at the age of four, five and six and seven. If we take out a primary or baby tooth too early, we are violating the laws of nature. And the result is that we have many arch collaspes,

many growth and developmental problems because we had an early caries attack and then didn't have adequate follow through as far as that particular child is concerned. So I am extremely interested and emphatic about the point. Let's take a look at prevention, let's take a look at the things we can do and what can we do about it. Number one - I believe that each of us regardless of what our area of interest might be as we have our interest and our influences in the educational system of the state of North Carolina. I don't think there is any other alternative than to teach the fundamentals of health in its very broadest sense to every child in every class room in the state of North Carolina, and I don't think there is any defense or any statement that you can make that will contradict that sort of a pattern. There isn't any other reproach to the total health problem. It is within the denistry that will teach the fundamentals of health including dental health to the pre-school child, yes, and to every classroom,that includes the high school. That means that if we are going to approach this total problem it means to teach the teacher the fundamentals of health and to incorporate and intergrate that into a total pattern. That's number one point that we can do, that can be done in the county school system, rural school system, city school system, and what. Number two. I believe that we all have to recognize certain fundamental inherent interest in nutrition which was expressed this morning. And that is true from a dental health point of view, preventive point of view, that we have to have an adequate nutrition program for growth and development of the body growth and development of the teeth, face, and so on. That is number two. Number three - we have an adequate home care and, in this presentation here, in this sheet here is expressed at least certain areas of home care as far as the individual is concerned and the family is concerned. Item number four. I'm convinced beyond any question that if you've ever had a caries attack - that is, a dental decay, there are still many other problems relating to denistry,

and dental problems other than dental decay. So what I would like to say is this, that from the age of two we would strongly recommend not later than the age of three, but preferably the age of two, that we have routine visitations to the dentist. Item number five - and that was approached this morning. That was related to flouridation of communal water supplies and we recognize and know there is unquestioned scientific evidence for those of us who are interested in the facts of science, cannot deny that the inclusion of one part per million of sodium flouride or some flouride in a communal water suppy would reduce the caries experience. Not the total dental problem - no - but the caries experience by about 50 or 60% of the growing children of that community and so we strongly recommend that area, and for those homes, those rural homes or those communities where they do not have communal water supply that would permit flouridation of water, we do recommend the topical application of sodium flouride. So denistry is interested in prevention, it is interested in infection, it is interested in growth and development and all of those areas and then there is this little saying, "Be true to your teeth or they will be false to you." In the profession of denistry, I think is very well represented here today by Dr. Walker and I think some fourteen other individuals that I have counted in this audience and I am delighted and happy that we have the opportunity to participate. Individually and collectively we are ready to help you with your individual, your family, community and state problems. Thank you so much.

REV. HENDRICKS: Thank you, Dr. Brauer. Our next speaker will be Dr. J. Street Brewer. He is Past President of the State Medical Society of North Carolina in 1952---1953, former Chairman of the Rural Health Committee, and is now serving as Chairman of the Committee Studying Construction of Small Community Clinics for the North Carolina Medical Care Commission. A native of North Carolina, a rural physician from Roseboro, he will talk to us about the need for, and the value of,

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physical examination, something that our people in many rural communities do not give much attention to. Dr. Brewer.

DR. BREWER: Ladies and gentlemen, I'm just a country doctor so you can just get out your fans and sit back and relax because I don't have much to say. We will get along with it though. I am here to talk about physical examination, as a part of preventive medicine and it is an important part of preventive medicine. We advocate periodic physical examinations as part of preventive medicine for people in good health because of a possibility of detecting incipient diseases. Incipient diseases are those like tuberculosis, leukemia, pernicious anemia, cancer. They sort of slip up on people. If all these diseases started out with a bang, like a person with renol colic, or appendicitis, or pneumonia, we wouldn't be so much concerned about physical examination and periodic health examination, because these things I just mentioned send people to the doctor. But too often things like cancer, tuberculosis and leukemia, etc. don't manifest themselves, the patients do not know they have it until it is too late, but there are certain ways that can detect some of these things by various examinations. You get sick and go to your doctor and he makes an examination and prescribes for it -- that's a physical examination for curative purposes, but when you are not sick and go to your doctor for an examination, which I like to call a health assurance examination because when you have such an examination if you are found to be all right you have assurance that you are in good health and if it is found something is wrong, your doctor can usually assure you that something can be done about it, so let us think of this in terms of a health assurance examination. Well, since our bodies and our lives are our most precious possessions it is a wonder to me and I know it is a wonder to you, why it is that people are so negligent about good health care. They don't have any hesitancy about having their automobiles inspected periodically. Now pretty soon we will see in the papers and we will

hear over the radio about taking your automobiles to some oil company or some garage, and get your winter check over and get your car in proper condition for winter service. Most people will do that, then since health and lives are their most precious possessions why aren't they equally concerned about taking their body periodically to the doctor to find out if anything is wrong with it and if so, do something about it. Well, they don't do it, and health workers and doctors have to get out and try to sell these people on the idea of the importance of this kind of examination and you people, you health workers, those out there in various fields of health committees, the Grange, Farm Bureau, can do a better job in your community than your doctor can because there are a lot of people that suspect when doctors say too much about it he's just interested in that $5.00 he is going to charge. So there is a great opportunity for people of all walks of life, particularly in the health services of the Grange, Farm Bureau, and so on, to stimulate rural people to go to their doctor for a health examination. Now I said a moment ago, why is it that people are not interested in this thing, why don't they visit the doctors' offices more than they do and learn what is wrong? Now, Dr. Emerson P. Smith, who is Director of Economic Research Department of the U. S. Chamber of Commerce, attempts to answer the question. He said that most people have three or four confirmed beliefs. Number one is that the human body and mind require little maintenance and they will withstand a great amount of self abuse. And therefore they go ahead, working too hard, drinking too much, staying out too late at night or doing any number of things that will injure the body because most people have the feeling that nature is reparative and nature will take care of these things.Then he says they also have the idea that the consumption of a relatively cheap over-the-counter medicine will overcome any tendencies in the body to disease that may show up. As a physician, I'm amazed that otherwise intelligent people will go to the store and buy the so called

"patent medicines" and attempt to treat themselves.

Thirdly, Dr. Smith says that people are hesitant to incur expenses to offset ailments that they hope they don't have and they may never have. I think just now of the woman who hesitates to go the the doctor about a lump in the breast or about some pains in her abdomen, because she is afraid that he might find she has cancer. Of course, that is the very reason she should go. Too often she is afraid the doctor will confirm her suspicion. So then by that token they hesitate to go to the doctor. They don't want to have these things and they hope they haven't got them and they say, "Well, I may never have them." So then they hesitate to spend their money with the doctor for a little examination and too often they say, "Well, let us wait until we get sick and then we can get our money's worth out of the doctor's fees." So that's that.

Now, what is a physical examination? You know, but it won't hurt to recap just a little. First of all, a physical examination should be preceded by a good history, now that is whether you are sick or whether you go to your doctor just for preventive health assurance examination, because out of that history he may get some leads such as diabetes or cancer or high blood pressure or Bright's Disease in your family. Then you might give him other suggestions, for example, which might lead him to suspect that you might have an ulcer or you might have gall bladder disease. That would be an indication for more work other than just a physical examination. He might see evidence of thyroid disease. So then the physical examinations are to be preceded by a good history, so don't be annoyed if you go to a doctor for a routine check-up and he spends five or ten minutes talking to you about your family history, what your father had and what your mother had and what your brother and sister had. Now what does this examination consist of? First of all it consists of inspection: the doctor looks to see what he can see, and sometimes he may see a lot of things. He may see the veins

in your neck pulsating; I won't go into what that might mean. He may see that your eyes are protruding a little, that your neck is a little large, and that will immediately suggest to him the possibility of thyroid trouble. He might notice that you have a clubbing of fingers and that might suggest some disease of the lung. So don't be annoyed after he gets your history if he sits there a moment or two and just stares at you, that is a part of the examination. Then the next part of the examination is palpation---he feels of you. He may lay his hands on your chest and ask you to talk and say ninety-nine or one,two,three. That's the transmission of the voice sounds through the skin, that has certain significance. He may feel a thrill when he lays a hand over your heart which indicates certain types of cardiac disease. He may examine you all over, and that reminds me of a story and I don't know why I thought of it but it just popped in my mind about this old lady who had been in the hospital for some weeks and she was a convalescent---she happened to be a little hard of hearing. In the meantime there had been some question about the final diagnosis and a visiting specialist from the city was coming to town on a certain occasion and her doctor told her that he was going to have this doctor drop in and see her and see what he thought about her condition. Well, in the meantime there came a new preacher to her church also. He had moved in and learning that this member of his church was ill and in the hospital, he had sent word that as soon as he got adjusted he was coming around to see her. So this morning her granddaughter was sitting there with her and someone knocked at the door and the girl got up and went to the door and this man introduced himself as Dr. So and So and said he had been asked to come by and examine the lady. She invited him in and he walked over to the bed and asked only a few questions as he had been told the history. He proceeded to make his examination and excused himself and went out. After he was gone the old lady on the bed said to the granddaughter, "Annie, you say that is the new preacher?"

She said, "No, Granny, that is the new doctor." "Well," the old lady said, "I thought he did feel over me a whole lot for a preacher." So the doctor, when he gets to palpating, he may have to feel over you a whole lot, too. Then he thumps you to see what kind of lumps there are there and where there is air, and where there is no air, then he takes out his stethoscope and listens to your heart and lungs. He takes your blood pressure, then he does a urinalysis and checks your kidneys, and he does other sorts of examinations, looking for the possibility of an incipient disease. He examines all the orifices of the body in search of early cancer. And he may do a lot of other things. Then he may decide to have a blood count made. That's to check on your anemia, and whether you have got any indication of other blood disease. But sometimes he might skip that. He may know you well enough to know that's not indicated in your case. Now then, in a course of examination he may find out that you are perfectly normal, that you are all right, but then he may find certain things that are a variation from normal. And then the question arises in the mind of the doctor - are these things just normal variations. There are a lot of variations from normal that are not going to be of any significance. Maybe he has had that big red nose for twenty years. Then the doctor decides from what he finds how much accessory work shall be done. Is there any indication in this case from the physical examination for x-ray examinations, not x-ray examinations of the lungs because we are going to have that as routine. And I want to endorse what I believe that Dr. McGavran said about routine x-rays on everybody's entrance to a hospital. It is a fine way to pick up incipient disease in the lung. Everyone should have a chest x-ray yearly. I will give you an illustration of that. Three or four days before the end of September, one of the school teachers at my home, a woman who looked in perfect health, and whom I have known for some years came in to me for her examination for her teacher's health certificate, and in the x-ray examination, on the x-ray film,

After the examination the doctor will decide whether you need to have any special tests and other x-rays. Something in history and/or the physical examination may indicate that you should have an x-ray of the stomach, or the kidneys, or some other part of the body or certain special laboratory tests might be indicated. If your doctor should request these additional examinations and tests, don't be alarmed for in most instances the tests will probably prove negative. The doctor had them done because in your individual case they seemed indicated and he did not want to leave any stones unturned .

Now I raise an important question. Who is going to make your regular health assurance physical examination? May I suggest your family doctor? Your family doctor is the one who already knows a lot of things about you and your family history. From previous contact he has learned of your pecularities, if any, of the variations in your body physique and normal body functions. He will, therefore, be best qualified to determine if any variations from the normal are significant in your case. But some of you may say, "I don't have a family doctor." In that case, allow me to suggest that you engage one right away and have him start by giving you a complete and comprehensive examination and record the findings. Suppose you were suddenly taken ill and carried to the hospital and the doctor there found your case puzzling. He would ask about your blood pressure, had anything ever been found wrong with your kidneys, ever had any suggestion of diabetes, your heart is skipping now; has it done so before? The electrocardiogram is not normal but not too definite. Have you had an electrocardiogram before? There is a suspicious spot in your chest x-ray. If that was there a year of two or more ago it is not too significant now. Who is your family doctor that he may call and ask about these things?

Ladies and gentlemen, don't you now see the importance of everyone having a family physician who is keeping a record of your medical history and examinations.

Whom will you select for your family doctor? Of course, I believe it should be a good general practitioner because your family doctor should be the supervisor of your health affairs whether you are well or ill. When one builds a house , he selects an architect to take over the whole job of laying out the plans. He may call on various specialists to lay out plans for the heating system and the air conditioning system and another for the electrical wiring system but the architect is responsible for the fitting of the plans and recommendations in the whole body of your house, For the construction you will employ a general contractor though he may sublet certain specialised parts of the job to special workmen trained in that field. Likewise in the care of your body in health and disease you should have a general supervisor who can visualize you as a whole and not as a part, but who will call to his aid specialists in the proper field when some organ or part of your body needs special treatment that only one especially trained is qualified to give. However, if you prefer some friend or acquaintance who limits his practice to some particular field as your family or personal physician you can get along. However, I understand most specialists prefer not to act in the capacity of family physician. The important thing is that you, everyone, should have a doctor with whom you are acquainted and who is acquainted with you, and to whom you can turn when any question of your health or any medical emergency arises.

To summarize, let me urge everyone of you to spread the gospel of regular periodic physical examinations with a chest x-ray at least once a year for everyone and secondly, may I urge again the importance of every family and everyone that is not attached to a family having a family or personal physician. Only in this way can doctors fulfill their proper role in the preventive health care of the individual. Thank you.

REV. HENDRICKS: Thank you, Dr. Brewer. I hope that as questions come to us, you will be making a note of them because we will have our chance in just a little

bit now to get these questions before the panel here. Our next speaker was born in Chicago, is a graduate of the University of North Carolina, did graduate study at the University of Minnesota, served with the United States Public Health Service for a time, and at two different times has served with the North Carolina State Board of Health. Since 1951 he has been Chief of Sanitation Section, Sanitary Engineering Division of the North Carolina State Board of Health. Mr. John Andrews, we are glad to have you talk to us about Sanitation and Health.

MR. JOHN ANDREWS: Sanitation was one of the first services performed by health departments. In the early days, the principal concern was the elimination of filth and odor nuisances and the "sanitary officer" performed a police-type function. Next, the practice of sanitation was concerned with those environmental factors which are important in the spread of the insect-borne and filth-borne diseases, including sewage disposal, water supplies, milk, and food. Methods were developed for the purification and protection of water supplies, for the disposal of sewage and other wastes, for the sanitary production and pasteurization of milk, and programs were developed for the sanitary supervision of public eating places and other food establishments. Today, sanitation is tending towards activity beyond the realm of preventing disease outbreaks, and concerning environmental factors which promote better health and living standards. The National Sanitation Foundation says: "Sanitation is a way of life. It is the quality of living that is expressed in the clean home, the clean neighborhood, the clean community. Being a way of life, it must come from within the people; it is nourished by knowledge and grows as an obligation and as an ideal in human relations."

As the scope of sanitation has changed, the type and quality of men who do the work has also changed. The untrained "sanitary policeman" was replaced by the "sanitary inspector", who has now been replaced by the trained "sanitarians"

now employed under the North Carolina Merit System. The "sanitarian" aims to accomplish his objectives by explaining, encouraging, promoting, demonstrating, teaching, and participating in community projects; he uses the penalties of the law only when education fails---as it sometimes does.

In North Carolina, sanitation work is largely decentralized among the 69 local health departments in line with the general philosophy that the health needs of a county can be served best by a health department which knows and belongs to that county. In the 69 local health departments there are now some 218 sanitation workers, and the State Board of Health has a small staff of district sanitation supervisors and specialists. The local sanitarians are a part of the health department team, working under the medical health officer together with the public health nurse, clerks and other specialists.

Sanitarians carry on two general types of work; inspection services required by State law or local regulations, and promotional activities. I think you will be interested in a few figures on the work of sanitarians, because several of their services not only contribute to the health of the public in general but also constitute a worthwhile service to rural living.

Under state laws, routine sanitation inspections are made of more than 15,000 food and lodging establishments. According to our latest biennial tabulation (as of January, 1953), these included 168 abbatteirs, 91 frozen food locker plants, 1,103 lodging places, 432 institutions (such as private hospitals, educational institutions, sanitariums, etc.), 5,626 meat markets, 171 poultry processing plants, 5,648 restaurants, 1,521 school lunchrooms, and 89 summer camps. The inspection procedure involves a careful inspection of the establishment, including facilities, equipment, methods, and cleanliness, using a standard inspection form and resulting in a percentage score. A sanitation grade placard is posted where it can be seen readily by the customers. The grade A placard means that the score

was 90% or more, the grade B means a score of 80% or more, but less than 90%, and the grade C means a score of 70% or more, but less than 80%. Places receiving a score of less than 70% are not permitted to operate.

During 1953 almost 35,000 inspections were made and grades posted in these establishments. It would be desirable to make inspections more often than the 1953 rate of about twice yearly, but greater effort and more personnel will be needed to reach our working goal of quarterly inspection. It should be emphasized that an effective inspection involves a great deal more than simply filling out a form. A good inspection involves the explanation and discussion of deficiencies with the management, the suggesting of methods of correction, and the development of an improvement schedule where this is indicated. Local and State sanitarians endeavor to go beyond the call of routine duty and assist management in planning for remodeling or expansion of the establishment so as to comply with the principles of sanitation as well as to accomodate the planned operations. The State Board of Health is rendering a planning service which has helped approximately three-fourths of the abattoirs, locker plants, and poultry processing plants during recent years, for example.

Another important activity of our North Carolina sanitarians is the inspection and sampling of milk under uniform local regulations on milk sanitation. Since 1924 the State Board of Health has encouraged the local adoption and enforcement of the U. S, Public Health Service Milk Ordinance and Code. At present, such regulations are in effect in all but six of our 100 counties. In 31 of them, the pasteurization of all market milk is required. More than 5,000 dairies and 100 pasteurization plants are under supervision, and milk samples ---probably numbering at least 50,000 per year --- are tested in local or regional health department laboratories. The health department's approval of a milk supply as meeting Grade A standards is an important -- and actually an essential---asset of

the entire industry.

Many counties require that septic tank installations be made under a permit and inspection system conducted by the health department. In 1953 some 18,813 approved septic tank systems were made in the state. Some jobs required as many as four visits.

The educational and promotional activities of sanitarians cannot be discussed in any detail for lack of time. In any community there are usually a number of needed improvements which could raise the standards of sanitation and cleanliness in the community. The alert sanitarian is anxious to work with civic groups and other agencies to encourage such improvements. One example of educational activities is the so-called foodhandlers schools, through which many thousands of restaurant workers have been taught the importance of sanitation in their daily work, and some of the rights and wrongs in food preparation and serving.

Despite great progress, there are today many rural sanitation problems. A few of them are outlined briefly below, together with some possibilities for solution.

You are all familiar with "fringe areas" outside the city limits, where many people may live without public water and sewer systems, without municipal garbage collection, and without zoning restrictions, but <u>with</u> many sanitation problems arising from individual attempts to provide substitutes. The fringe area problem is a growing one. A survey of 15 North Carolina cities showed that from 1940 to 1950 the population density of the fringe areas increased at three times the rate in the cities. A solution to the fringe area problem is the creation of a "Sanitary District" by community action. The problem and this solution were ably discussed in the article "Fringe, Unincorporated", but Ramsaur and Long, in the January, 1953, issue of the Health Bulletin published by the North Carolina State Board of Health.

The problems of unsatisfactory collection and disposal of garbage throughout a county can be attacked through the power of the county board of health to adopt and enforce rules and regulations. For example, regulations adopted by the Guilford County Board of Health in 1951 govern the storage, collection, transporting, and disposal of garbage and refuse in the county. Among other things, these regulations provide that no one on private or public premises shall allow garbage or refuse to accumulate except in covered containers of approved type. Such regulations provide the mechanism for solving the problem under consideration, if provision is made for enforcement of the regulations through education and inspection. Community action can bring this about.

Private sewage disposal facilities are of special interest, since the State Privy Law was one of the first sanitation laws adopted in this state. We recently made a tabulation from the 1953 annual reports of the local health departments of their estimates of the number of homes depending on private sewage disposal units, as differentiated from those served by public sewer systems. Approximately 798,000 homes depend on private facilities. Of these, 333,000 were said to have approved facilities, either septic tanks or privies. According to the 1950 census of population, agriculture, and housing, about 38,000 rural farm households lack any kind of toilet facilities. These figures indicate a substantial problem. However, during 1953 8,752 sanitary privies and 18,813 septic tank systems were approved — a total of 27,565 approved installations.

As for private water supplies, the same 1953 reports indicate that about 550,000 homes in North Carolina depend on private water supplies, and that about 200,000 of these are well protected from the possibility of contamination. Bulletins on water supply protection are available at the local health departments, and the sanitarians will gladly advise property owners on well locations, methods of pretection and disinfection, and will collect samples from the supply, after

disinfection, for bacteriological examination.

Food items prepared by volunteer workers and served at group social events, picnics, etc., have occasionally -- but too often, nevertheless -- been responsible for outbreaks of food poisoning or food infections. Such outbreaks are often spectacular, usually embarrassing to the sponsors of the event, and are preventable. Probably the most important single factor in these outbreaks is inadequate refrigeration of foods which are good culture media for germ growth. Such foods include meat salads, potato salads, meats, pastry items with custard or cream fillings, and similar "perishable" foods. The importance of prompt and adequate refrigeration of such foods should be more widely recognized. The armed forces have rules that no such food shall be kept out of refrigeration for more than two or three hours, unless it is being cooked or held, as in steam tables, at such high temperatures that germ growth is prevented by heat.

Other problems could be listed -- such as the control of disposal sites used by itinerant septic tank "pumpers" -- but each community and county may have special and different problems which are known to its citizens. The county health department has a great deal to offer the citizens in solving these problems. Some problems can be solved through laws and regulations, others cannot. In all cases education and community action are of paramount importance in achieving lasting results. In the final analysis, it is up the the community or county to determine its standards of sanitation. If low standards are desired, low standards will prevail. If high standards are desired, high standards will be achieved, for then the community leadership will demand more and better sanitation services, will support the organized sanitation program of the health department, and will encourage the employment of more well-trained sanitarians.

There is a great deal of truth in the statement by the National Sanitation Foundation which I quoted at the start and which begins: "Sanitation is a way of life."

REV. HENDRICKS: Thank you, Mr. Andrews. Our next speaker will be Mr. Ralph J. Andrews, who is the Director of the North Carolina Recreation Commission. Mr. Andrews has been nationally recognized for his leadership in the field of recreation, and we are pleased to have him to participate on our program and to tell us something about recreation in North Carolina. Mr. Andrews.

MR. RALPH J. ANDREWS: Thank you. There is one advantage of being the last speaker on the panel and that is that you have the opportunity to make some corrections. I would like to call attention to one of the earlier talks by Dean Brauer where he made the point that the field of denistry is very widely of great interest and he made two other points - that it was one of the most popular fields and the most economical. I would like to call attention to the fact that it is not one of the most popular fields to those of us who go and that it "ain't" economical. He also referred to his field as one of the upper level medical areas of work but one of my good friends, Dr. Will Menninger, who deals at the famous Menninger Clinic with nervous and mental ills, even goes on a higher level than he does. One of his statements, and I would like to bring it in here early, is that a great many of our ills of today, individual and group, could be corrected, could be anticipated and prevented were we to be provided with adequate recreation opportunities. It used to be that recreation was thought of as something to be promoted on a playground for youngsters, but with the great number of people who are growing into our older age groupings, we have need for a great many aspects of recreations that few years ago were thought of just as luxury items. We have here in North Carolina a fortunate background that work with recreation for the aging and recreation for our older citizens, the proceedings of two regional meetingswhich have been put up into booklet form by the North Carolina Recreation Commission and made available to this country. They are available to you as are other of our services at no charge. We have a unique

set-up as was told to you. The North Carolina Recreation Commission was the first to be established in the world. Israel has followed our plan, Vermont came up with a plan similar to ours; California was next. There were about 13 other states that were followers. We think that in many ways our chronological first has continued as a functional first because we work with people only in trying to help them to do things which we recognized needed to be done. One of our basic precepts is to help people to help themselves. We only go out to work with the community or with a private agency or with an industry or with a business, or with camps or with resorts, or with any of the various aspects of recreation, when they ask us to go out and we don't go back unless they ask us back. So we are not an imposed sort of state service.

To attempt to serve in these areas of need, we have opportunities for service which are surprising to those of you who haven't had a chance to come into our office and see them. We got a request from a lady down in the eastern part of the state who lives part way between a small community and a mill. This lady, of her own volition, has gone out and bought a small park area. She is attempting to develop this area for the use of youngsters, younger married,couples, and even the older people in the area. So she is referred to the North Carolina Recreation Commission. We send one of our people there to work with this group, to do as much as we can in the way of general planning. Then we call Fred Gregg's office over in the Forestry Division and he sends the man down and he helps him to mark the trees and to make provisions for proper cutting and proper retaining of those which will contribute to their program and in other ways we make referrals. We have as many as a dozen, sometimes in one day, of referrals to other departments of state government. Within our commission we have an advisory committee of thirty members, these are selected from the outstanding recreation interests throughout the state. I know that Mrs. Maurice Honigman at Gastonia has done an

outstanding job in work with music, and with many aspects of music work in recreation. We have these people throughout the state who help us to intrepret need and then to give assistance in satisfying these needs. Then we have a group of consultants who work with the commission. These consultants come from agencies of government, local, state, regional, and national. We feel free, and they feel free, to refer back and forth problems which can be answered better either by their organization or ours. There is a constant interplay of this sort of thing. It brings about the best, most efficient use of those facilities, which you, in North Carolina have provided to bring human services to the community. One of the things that has concerned us, right along, is the fact that we not only in our organized community work have been faced with the problem of providing recreational opportunity, but we many times, have to provide an opportunity to learn recreation skills. This is certainly true in the areas of the age grouping of grade school children. We haven't a real outstanding physical education program that will give the nervous and physical power that vigorous physical exercise will bring about. As a result, many times, that sort of thing has to be brought into the program as the volunteers come in and participate voluntarily or direct activities voluntarily. The significance and importance of recreation is increasing and being recognized by you people. We know that because of the impacts that your awareness is making on our program. Every indication on the social horizon points to the fact that recreation is going to continue to be more significant as a factor in personality development and in community, social well being. Today it takes place right along with work, health, religion, and education, as one of the five fundamentals in development of an individual and the community. A tempo of time clearly indicate that this significance will continue to increase in importance.

Recreation, and this is especially true in North Carolina, has come to be a

tremendous economic factor in the life of this country. It's estimated that it is a 28 billion dollars business each year. Sports alone at 9 billion, crafts at more than 3 billion, tourist industry at more than 3 billion, and so on. It is a producer of goods, a consumer of goods, and an employer of people as well as a way to broaden the life experience of our citizens and at the same time to do many of the concomitants that go along with something of this sort of community service. I have reference to those that you have heard more often sometime and you add the fact that it gives to broaden living experience namely that of juvenile delinquency prevention and others of that type, but those things are parts of what you get in your recreation programs. I could name you a town, not far from here, a mill town that until they got their recreation program, the delinquency reports were well up into two digits each month. The police chief says that since the third month they developed an organized program in that town they never yet had the delinquency report in two digits.

Unless health education is tied closely to interest and activity it is not going to work too well with youngsters. It's been my very pleasant experience to work with youngsters in schools, in athletics and physical education in grade school right through graduate school and even in the state Department of Instruction. I have seen some mistakes made in the promotion of sports activities for youngsters. We felt that that had gone to the point that something needed to be done about it and we made a study and I brought a little booklet on Activities for Children, this booklet received a good deal of national attention. We know that some errors have been made in that sort of recreation promotion but on the whole it has been good. It has provided something that otherwise would have been a vacuum in youngsters' opportunity. There are ways that can bring this about in your community. You can bring about improved recreational opportunities, that's one of our interests, one of our great interests. We believe

that there is a great deal to be accomplished through recreation. We have seen them do it in towns and villages in seasonal programs, and in year-round programs, and we have more of them go down further in a smaller town than probably any other state in the United States. Since 1947 that's been brought about. But there are ways that you can do it.

When the Challenge group developed their brochure and their pamphlet, it came out looking something like this. So they asked us to go a step further and develop one for recreation, so this came out. It's "Seeds of Happiness" - recreation for rural living. Within that bulletin are a number of steps that you take and it tells you something of the expected harbors that you can look forward to. Recreation brings a sense of security of recognition, of response, of new adventure. Recreation is a partner of good health and it is prerequisite, and increasingly we are getting referrals from mental hospitals back to the recreation departments of the small towns because they found that it not only prevents, it cures, and it helps in the permanence of rehabilitation. On another page of this bulletin, which you can refer to, and which we will be glad to give you, are the steps in organizing a county recreation system and I think that that next big development in recreation in North Carolina will come about to legal organized recreation departments on county basis, coordinated where possible, with existing city recreation programs tied up and coordinated certainly with all of the community programs that are within that county. You are not going to get an organized recreation program unless this is done. I think that if you can get with your county groups and make them articular in giving to their county commissioners this need, then you can get it. We have sample ordinances all set up, we have several counties that are in the process today, we have steps to be taken and then after you get into the program we can come in and help you with the program and you can get many other aids from these other organizations -- 4-H, Home

Demonstration, Grange — all of them are interested. We work with all of them in your interest and unless we are certain of what you want, then we are not doing it right. We think we are, we wish you the best of recreation. Thank you.

REV HENDRICKS: Thank you, Mr. Andrews, I am going to ask the members here on the panel if they would please remain here so that we may direct questions to them and call them by name if we want to do that. I will ask first that Mr. Morris McGough come to lead us in our first part, what are we doing now about these problems that have been brought before us today. One of the most interesting community development projects in America is in western North Carolina - the Ashville, North Carolina Agricultural Development Council and Mr. McGough is Executive Vice-Chairman of the council and will now focus our attention on what is being done and will lead our discussion on that.

MR. MCGOUGH: Thank you very much, Rev. Hendricks. Ladies and gentlemen, at first I want to express my very deep appreciation for this opportunity to be here with you for the Rural Health Conference. I've certainly been impressed today throughout this conference by the great deal of emphasis which has been given to this idea of solving our problems to community action, starting off with the slogan of this health conference, "Community Action the Key to Rural Health's Door." I think throughout this entire conference that the key note has been continually brought before us the fact that the way we are going to solve so many of these health problems, that we are confronted with in North Carolina today is through community action and through working together. And I think certainly that is the way we are going to solve these problems, we have made tremendous strides in the past, we are going to make even greater strides in the future, because of the fact that we do realize more than ever before the great benefits that can be achieved by working together and speaking of working together through community action, what I am thinking about in my comments are primarily from the standpoint

of these small rural communities, because that is the phase of the program , the type of work that I am most familiar with and of what these communities are doing by working together. That brings us up to the question of how we are going to solve these problems that have been brought up here today by this panel. We have heard these four excellent speakers outline to us some of the problems that we are faced with from a preventive standpoint - of the prevention of disease,of the prevention of other health problems here in our rural areas of North Carolina.

Certainly that brings to my mind this - the fact that I saw this figure not so long ago that out of the average medical expenditure of farm families of North Carolina, only 3% of that medical expenditure goes to the prevention of diseases. Only the rest of it is on the curing of diseases after we already have them, and I think certainly that brings to you, focusing before us very vividly the thing that these gentlemen have been talking about here today of the prevention, of what we can do about these dental problems, about the health check-ups, about the sanitation, and about the recreation in our communities. As I said a minute ago, the only way in the world that I know of that we are going to be able to solve these problems, the only way that we are going to be able to attack them and the most efficient and the most effective way is by working together out in our communities and it is going to take the entire mobilized effort of the people in the communities. I don't think that we can demand on any one small group, or any one small segment of the community, but we are going to have to stir the vision, the imagination and the initiative of a great percentage of the people in the community because it is only through the mass participation in the communities that we are going to be able to tackle these problems in the scope that they should be tackled.

The Bible tells us that where there is no vision, the people perish. How else are we going to get these programs underway in our community except that we

have vision first? The people in our communities, we curselves, have to have visions of what we want, we have to have a vision of a better community and a better way of life, we must create within the community the desire for better living, the desire for better health and then and then only as the desire is created are we going to find the problems that confront the communities and then and only then are the solutions to those problems going to be forthcoming. So I think that first we need to be concerned with the stimulation of desire. And then after the desire is stimulated in the community, after the people in the community get the vision and desire to go ahead and to build a better community and to help better living, then to study the problems of the community to find out what our problems are. I don't think we are going to even worry about what our problems are until we get this vision that we are talking about, and then when we get this vision and desire, then the folks in the community themselves are going to find out what the problems are, and as it was brought out here this morning, the problems vary so much by communities, and certainly if we are going to carry out the program and if the people in the community are going to carry out the program, it's going to be up to the people in the community to determine what their problems are, and then after they have determined what their problems are, the problems that appeal to them, the things that they regard as the problems, then through organized efforts can it move into the action program of solving these problems and to get these various projects underway in the communities.

Now in western North Carolina, as Rev. Hendricks mentioned, we have the community development program, as is true in many other sections of North Carolina. This year there is a total of 104 small rural communities organized in working together in the community development programs. These communities have been organized for one purpose and that is to build a better community - to build a better community in which to live and build a better community to raise a family,

and to have better family living. As a part of their over-all program, a great many of the communities have launched out on health programs. I would like to cite to you just two or three examples of what some of these communities have done by working together in an organized effort and let me say first that certainly the things that these community clubs have done hold true to Home Demonstration Clubs, the Grange, the Farm Bureaus, and other organized groups throughout the state. I might mention first the community of 74 families, the name of it is the Big Cove. Big Cove Community of the Cherokee Indian Reservation, a community of 74 families about 20 miles up a little gravel road from the town of Cherokee, North Carolina. This community had a meeting one night of February, 1952. They were interested in trying to build their community, to have a better community, so they got together and had a community meeting, and tried to organize a community development program. That night they had eight people who showed up, eight people who showed that they were interested in their community. But this little group of leaders said, "Well, we've got to bait them, the only way in the world that we are going to build a better community here is to put some unselfish work into it and try to get the other folks in the community together and we will all go out here and tackle this problem." So they organized a community development program. Last year that community had 25 community meetings and averaged 195 people per meeting, in that little community. The night they organized this community they had two painted houses out of 74. As one of the Indians said, "This community has been here since the Indians have." At the end of the first year of the community development program, they had 28 painted houses. When they were judged last November in the community development program, they had 46 painted houses. They had gone from 2 painted houses to 46 in a period of about eighteen months. Why had they done that or how had they done it? They had done it because the vision and desire for improved living in a better community had

been stimulated in those people, and when that desire was created, they found the ways and means of getting these jobs done.

Another thing they did - last year, from the health standpoint - they built 20 sanitary toilets as a community project in that community. Now we may question, "Well, is that a great improvement to build 20 sanitary toilets?" But that was building and putting in 20 sanitary toilets where there wasn't a toilet of any kind. To me that indicates progress, it indicates progress on a problem that was a problem to that particular community. Now they got together and had a community working and built these toilets and then they sold them to these folks and if they didn't have enough to pay for them, they let them pick blackberries. They took the blackberries and made jelly and sold the jelly. We talk about different problems to be solved and different ways to solve them in the different communities. This community set up a health committee, and a very active health committee has been functioning. Each year for the past two years this health committee has visited every family and discussed with them what they were trying to do in the community from the standpoint of sanitation, from the standpoint of immunization, chest x-rays, and things of that sort. Just impressing on the people that visiting the families and also at the community meetings about what could be done there in their community, what some of their problems were there in that community. Another thing this community did was to get electricity. They had been told that it probably never would get electricity, it cost too much to put it in there and they were not sure that anybody would take it if the lines were run in there. So as a community project, this community went out and cut a right-of-way 22 miles long and 40 feet wide to bring in electricity. And August a year ago they had a big eelebration, a celebration of turning on the first electric light in this community. Three months later they had 56 families who were hooked on with electricity in that community, and today nearly every family in that

community will have some modern convenience - either a refrigerator, or an electric stove, or an electric washing machine. I think now they have some 40 odd washing machines in that community. To me again that represents progress because it represents what can be done by working together and that's the way we are going to have to tackle this whole health problem in our community, it seems to me, because there are some things we can do as individuals and some things we can do as families, but there are a lot of other things, and I think this health problem falls in that category, it takes all of us working together to solve that problem.

The health program needs to be tied down in the communities to some of the, I guess you could say, fundamental problems or some special projects, something that people can see. Things like sanitation, or holding demonstrations on septic tanks, or building toilets or whatever it might be, or health campaigns or putting in sanitary facilities at churches. Things of that sort that are the type of projects that people can see and the type of project that will stir the initiative and the imagination of the people in the community to even greater heights.

Another community I might mention, Brush Creek, over in Swain County, is organized this year. One of their first projects from a health standpoint was to get all the out-houses off the creek. A little creek runs down through the community and the out-houses are perched above this little creek - very unsanitary. I was over in that community about two weeks ago. They were telling what all they had done this year and they said, "We've got all these out-houses moved except one, we've got one that is still sitting above the creek," and they said, "Now a committee has been appointed by the community, and they have said that if that's not off that creek before this community is judged, the night before the judging, the committee is going to push it in the creek." So that's the thing you come into on a program of this sort where the people in the community are

stimulated, where you get a great percentage of people in the community stimulated, is that you are going to get the force of community pride and community spirit and the pressure of neighbors brought to bear on a lot of these problems which will give a solution to many of them. Other communities have held many types of health programs such as rabies control, rat control, and things of that sort. A community over in McDowell County held a nutrition survey with the Home Demonstration Club in the community. After this nutrition survey, the results of it were brought before the community and then they tackled it from the standpoint of trying to do something about improving some of the conditions that were shown in this survey.

Now I know that we have a lot of people here today that are better qualified to speak than I am on this subject of rural health and this is supposed to be a discussion period. I'm going to start calling on these people here and they may not be expecting it. I see Mrs. Simpson sitting over here from down at Forsyth County and she is quite a wheel for us in Home Demonstration Club work and community development work down in Forsyth County and I know she can talk. Mrs. Simpson, how about standing up and telling us a little about what communities are doing about better health, what's been done about some of these problems that the gentlemen have discussed here today.

MRS. SIMPSON: Well, this is unexpected. I certainly didn't expect to be called on. You're taking advantage just about like Neal Bolton does sometimes. In Forsyth County, we have entered into the third year of this community development program, and - of course - we have placed emphasis on health and growth, and we have put a lot of stress on recreation for the young people of our community. On Monday nights we have a recreation program for all of our teen-agers. We feel that if we can get this group of young people working together and playing together and being together and I don't know if you realize that in our young people that learn to do these things, we are laying down what you might say a

future peace program because it is only as we learn to work together, and play-together, and live together, that this problem of peace can be solved. In our health program in our county, of course, we have the pictures on cancer, we have one for women only, and then we have one for men and women, and I know that in a lot of these communities they don't have these films. I am sure that you could get them and use them. It does go a long way in putting before the people the importance of having physical examinations regularly, and we have our x-ray machine. This year they are going to visit all of our schools and x-ray all of the teen-agers. So I don't know just what I could tell you. I'm just one of the common laymen, out in the field, and of course our communities work on a cooperative basis and that stimulates a whole lot of interest and it's only as we put what we feel is right for our community in it. It's only if we give them our enthusiasm that you will get a response, you can't shake somebody up unless they see something that they really want. If you really want something you will work for it, but if you honest-to-goodness want it, you will sacrifice something to get it.

MR. MCGOUGH: Thank you very much. Mrs. Erby Walker, are you still here? I believe she is. Mrs. Erby Walker is with the North Carolina Farm Bureau and they have done a great deal of work throughout the years here in North Carolina with the health program; Mr. Walker, I wonder if you could give us some comments on some of the things that are being done in Farm Bureau.

MRS. WALKER: Well, Mr. McGough, our resolutions call for us to work diligently to improve the rural health standards of farm families and one of the specialized projects of the Farm Bureau women is in this field. Our State Farm Bureau women, when they adopted this project, did not make specific recommendations as to what phase of rural health the community groups in counties would work on because it has been pointed out so well here today, the conditions vary in counties and

and communities. But we do anticipate that a number of our counties will take projects which are needed most in that particular county. We have some very outstanding work done by some of our rural groups on sanitation already, and we are very proud of that. As I have listened to these discussions today, it has been brought very close home to me that one of the greatest diseases that we all have in this field of rural health, is this field of education. I think that all of us, particularly women groups, could use the facilities that we have at our disposal to help to do this educational job, to bring to all the farm people an awareness of the need for these regular check-ups and all these things that we have heard here today. We have our monthly publication as Farm Bureau Women have the Weekly News Letter which I am sure would be glad to use for this purpose.

MR. MCGOUGH: Thank you, Mrs. Walker. Is Mrs. Wanzer here? I have seen her chasing up and down a lot of these mountains up here in Western North Carolina recently. I don't know whether she is doing it for her health or otherwise; I suspect it had something to do with Hospital Insurance, so Mrs. Wanzer, I know both of the Blue Cross hospital companies have been doing a very good job in rural hospital insurance and I wonder if you could tell us some of the new advances that are being made from the standpoint of your company.

MRS. WANZER: Well, most of both Hospital Savings and Hospital Care, which I represent, are reaching a lot of rural people, but the same story comes out with us, as you brought out many times here today, that the desire has to come from the people. We like to go into a county and help put on a Blue Cross Hospital program to give the people a prepaid hospitalization if the people want it, so if there is a desire, we can go in and set up a program.

Now, that can be done in many ways. Maybe the way we will do it in one county will not be the way we need to do it in another county. There has been a great deal of work done through the Grange, the Farm Bureau, Home Demonstration Clubs,

and of course the shining example of the Haywood County New Development program. As you go back to your counties, if there is a need or there is a desire for prepaid hospitalization, we will be glad to help you.

MR. MCGOUGH: Thank you. How about Hospital Saving now? I know there must be someone here from Hospital Savings that might like to make a comment.

FROM AUDIENCE: I would just like to endorse what Mr. Wanzer said, we are both working on it, and it occurred to me through these discussions that the adequate hospitals and surgical protection are the end products of these things that you are trying to do, that we cannot go in and sell insurance first, expecting it to be a cure-all for these more basic problems which you are discussing.

MR. MCGOUGH: Thank you. Is there anyone else in the audience that we can call on for a very brief moment. I believe our time has run down to a minute or two.

FROM THE AUDIENCE: I would like to comment on something Dr. Brewer said as president of the T. B. Association of Wayne County and also Chairman of the Rural Health Committee for the Medical Auxiliary of Wayne County and that is, his endorsement of Dr. McGavran's reference to the routine chest-x-ray of all persons admitted to general hospitals. That is something that we are very much interested in and Dr. Brewer should go ahead and get his endorsement approved by the State Medical Society. I think it would promote that need greatly, because these people who go, it is well known fact that both doctors and nurses are more frequently infected with tuberculosis in general hospitals than in sanatoriums. And if the State Medical Society could endorse that, it would certainly help the local groups to get that move over and we are most heartily in favor of it for both rural and town people.

MR. MCGOUGH: Thank you. Who'll be next now?

FROM AUDIENCE: One question I would like to direct to Dr. Brewer. Mrs. Walker asked me the question sometime ago with Dean Colvard and Hamilton on this idea

of periodical health examination. Could we pin-point that to say every six months, every three months, twice a year or what not?

DR. BREWER: I think that first primarily depends on whether or not you have a family doctor. If you have a family doctor who treats you when you're sick, then when you are well, you may go to him say, once every year, or every two years for a complete thorough check-up. You may not need to go at all. If you are sick and you have a family doctor, he knows about these things. If you are one of the many people, and I regret to say there are many of then, who have no family physician, if they were to get sick tomorrow, they have almost the remotest idea what doctor to go to. If you are one of those people, and if you are past 30 or 35 years of age, you should have a check-up examination at least once a year. If you are younger, and you have ever had anything like tuberculosis or rheumatic fever or a few other things that I might mention, you should have your check or examination every six months.

MR. MCGOUGH: I think the lady right here has a question.

MRS. ANNIE RAY MOORE: I would just like to say a statement of one or two things for the schools and we who work in schools are certainly glad to see these organizations working for some of the things in the community and in the home that teachers have been saying are some of the reasons why they haven't been able to do a more successful job of teaching. That they have been able to teach but sometimes it can't be carried out because of home and community conditions. And so for all the teachers who are today at home looking after the children and can't be at the meeting, I would just like to say that I am sure they would be happy to see this kind of work going on and I would like to say for them and for me to work with the teachers and the schools in the program that they are carrying on. Our state superintendent last year issued a health education manual which all teachers have, or most all have, and are using and I think they are doing a great job.

MR. MCGOUGH: Thank you. Does anyone else have a comment?

FROM THE AUDIENCE: One other question and I don't want to monopolize the thing, is that Dr. Brauer in his message said the intake of sweets should be cut down to prevent decay. I want to ask specifically if the timing of this is specific, that is, between meals?

DR. BRAUER: Thank you. The average American today consumes about 115 pounds of sugar per capita per year. We know that within the first twenty minutes after we eat, after have the intake of food, sometimes we refer to it as food, sometimes it is refined carbohydrates, sweets if you please, that we have the greatest acid formation in our mouths. Now within the framework of our oral cavity we have some bacteria and if we feed those bacteria with refined carbohydrates, we can develop an acid condition which will destroy the teeth and that fundamentally is what dental caries are and it is very comparatively simple to say, "Let's starve the bacteria." Our average sugar consumption during the past 100 years for the average American has been increased by one sack of sugar, 100 pounds of sugar per year. So we would respectively suggest to reduce the sweet intake to an absolute minimum to help to control caries.

MR. MCGOUGH: Thank you, Dr. Brauer. In conclusion I would just like to make this observation, that is thie, that all this information that we have had here today, and all this discussion that we have had so far today, is not going to do a bit of good in the world unless we can take it back to our communities and to our homes where we come from and put it into action. I think we have got to get moving on our health program, we have to have action, we are just going to have to go after that better health. Thank's a lot.

REV. HENDRICKS: Thank you very much. Now for the continuation of this discussion. One other person is to bring some suggestions out of his experiences, then we will ask questions of him and these here on the panel. Dr. W. Wyan Washburn, a

former newspaperman, and now a medical doctor in Cleveland County, a general practitioner, who operates a clinic there in connection with Gardner-Webb College and serves a rather wide area. Some years ago a friend of mine who grew up in a wealthy home and a large city church went away to college, got his education, and became a minister in this rural church and had a very fine experience there. He went back to his home community and the minister felt obligated to ask the son of one of his most prominent members to preach, so rather apologetically he presented him on Sunday morning and said that they were glad to have this country preacher back to preach for them, and when my friend got up to make his beginning he said, "Folks, I want to say that there are country preachers and rural pastors, there are many country preachers in city pulpits, I claim to be a rural pastor." Dr. Wyan Washburn, a real rural doctor, who is serving the people of his community.

DR. WASHBURN: Thank you, Mr. Hendricks. We are going to go home now and start talking about these things. You've heard them all, I made a list here just from today of what has been brought up in this meeting, a list of 25 or 30 things that we ought to be thinking in terms of doing, and as we go along we are going to ask some of you if you have done those things or whether you can do them in your own home community. Now, one of the first things I am thinking in terms of and that's to hold a meeting. You know, we Americans have a wonderful custom of holding meetings. Well, the first thing I know that most of us going home will say, "Well, let's call a meeting together, let's get the community leaders, let's get the people, let's get everybody that's interested, let's hold a meeting." So that's the one thing that can be done. There are several kinds of meetings, there can be different discussions, there can be a panel. One of the most interesting things we did in my little community was to have a panel. We decided that at this particular meeting we would talk about cancer, so we had a panel on

cancer, and invited a half dozen doctors from County Medical Societies to come and sit on the platform and our local community people let them talk, just limited them to a few minutes of talking first and then we asked them questions. A panel will bring a wonderful set of ideas and it brings enough participation that people will enjoy it, and then there is another thing that we can all do and before we leave that one, let's see how many of you had a meeting on health in your community in the last year, will you hold up your hand? Well, let's see how many have had some sort of a meeting. Fine, fine, we are already holding meetings. Then there are other kinds of meetings, we could meet jointly with some medical group that's thinking about health, the County Medical Society. Now doctors are unusual people, you have already heard today that most of them haven't even learned how to write. But they do enjoy going to meetings and they have their meetings and I think there is an awakening conscience on the part of doctors in North Carolina to think in terms of the whole community and the general part of health. One of the reasons I think that is, is this meeting today, sponsored by the North Carolina Medical Society through its Rural Health Committee and I think you will find your County Medical Society ready and willing, they may not know how but they will be ready to help in a good many ways in approaching some of these health problems. Another thing that we can do and it was mentioned here is First Aid classes and life saving courses.

Other things you can do in your community - you can hold some maternal welfare classes, doctors and public health people will be glad to come and help us do it. We have already had discussion about playgrounds, recreation, and childran's clinics and just a little while ago we had a community mass meeting in our community, and unfortunately we just didn't know about you, Mr. Andrews, and I apologize, but we should have known about it instead of reading about it in the papers, but we are just not. We just went out and issued some invitations

and started talking about a recreation program and I can assure you that our community is interested in that sort of thing and will be calling on you. Several other communities in our county are also interested in recreation. I wonder how many in this room, since we are going to have a little participation, how many have had a chest x-ray in a year. Oh, wonderful! Now that's a thing that you can do that takes no effort, because most of our counties have an x-ray program, if not, certainly your community can help do it and we have heard the discussion on health insurance and sanitation and immunization, animal diseases, rat, mice, lice and insects and all those things, they still are very, very real. Now here is an organization I hadn't heard much about until just recently when I was talking to somebody and they said we have an organization known as the Jugs. I don't know whether you have heard of that organization. I hadn't, but it turned out it was "just us girls" - Jugs - but they dedicated themselves to the idea of becoming a hospital organization and a good many other things for health, and of course, we have the hospital auxiliary, and the candy girls, the girls in high school, who voluntarily give part of their time to something in hospital and health, and I want to say this - if women can drive 15 to 20 miles out of their own little communities to go shop at some big center, it is certainly possible at this day and time that they could also drive to the community hospital and spend a little time in the Woman's Auxiliary work, helping to do some things like that. Also help with the blood mobile and the cancer clinic and fix up the first aid room at the high school. Also there are polio, Red Cross, Easter seals, and the other voluntary health drives. I wonder if there is anybody here who has had an experience with this sort of thing? Has anybody prepared a county or community fair exhibit on health? Anybody? Will you stand up and tell us about it. Just tell us where you are from and what it was.

FROM THE AUDIENCE? I'm from Warren County and I didn't do it, my cousin did.

It's on the services of the health department in the county. We had had prior to that a meeting of each club, on the services of the health department and they brought this out in their fair booth.

DR. WASHBURN: Fine, that is splendid. Anyone else have a health project? We had several hands but we will pass on to the next one. There was a good many and they have been done. I wonder if anybody over here, did you do any other project in health this whole year, any organization or group, would you stand up and tell us about it? In this group - anybody who has helped in any sort of community project for health, would you tell us? You have, I believe, something on your mind.

FROM THE AUDIENCE: Our club gave two first aid rooms in two schools.

DR. WASHBURN: Two first aid rooms in two schools. Fine. Now, who else over here. Any sort of a health project, here you are.

FROM THE AUDIENCE: High school nurse training courses as a project.

DR. WASHBURN: Wonderful, classes in home nursing. Now those are the things we have mentioned, 25 or 30 here. What these communities can do, you can do. You can go back, as has been said, communities are just as different as individuals, but you can do all of them. I was so interested in talking with Miss Ruth Current this morning. She is doing more perhaps through the Home Demonstration Club women, I told her this morning they ought to change the name of that group of people to the Health Demonstration Club people because I start asking about the work they are doing - they have 12 programs a year, nearly everyone of them have something to do with health. How can you divorce sanitation from health or nutrition from health, all these other things about physical examinations and clean living, refrigeration, all of them are tied up in it.

FROM THE AUDIENCE: Dr. Washburn, I would like for you to call attention to suggestions about one particular thing that everyone can go home and do, and I am so

moved by the question on the program as to what communities can do that I'm up here before you. Now this is not a new problem. It's been sounded all through every talk that has been made today. It is not a new problem that we are bringing forth, it is a health problem but it has mental health in front of it. Mental health. There is a great deal that needs to be done and we all know that, and it runs right through every service that has been brought out today. We are all involved in mental health. None is divorced from it, but there comes a time, and I repeat, that there comes a time when there needs to be something, a particular something, and in that connection I would like to identify myself with the North Carolina Mental Hygiene Society. The North Carolina Mental Hygiene Society has seen fit to go on record as accepting as its main objective through legislature at least the approval and the sponsoring of the mental health program of the State Board of Health which relates to mental health centers. Now there is in that budget of the State Health Department $380,000, set up for the development of mental health centers, and why do we call these mental health centers? Because we want them to be regional, we want them to serve a larger area than the county in which they are located. We now have six clinics, the proposal is to develop these clinics into centers which would be strengthening those present facilities and to develop four more mental health centers. Now there is one thing you people know, but you need to have it called to your attention. You need to highlight it and that is that there is no mental health facility east of Raleigh. People in Dare County have to drive as far as Raleigh and Durham to get to an authority and that is one of the main reasons. Now you eastern people, pull and pull hard. These centers are proposed to be located in Elizabeth City, Wilmington, Greenville, and Fayetteville. Now then, that is all I have to say, if you will go home and join the Mental Hygiene Society in supporting this movement, you know how to do that. Do it in your own way, in your own community, and we will

have these centers.

DR. WASHBURN: Thank you very much. Now, let's see how many live east of Raleigh. Oh, that's a fine group. You've got a lot of people to help you pull. Thank you, and I want to call your attention to the mental health poster over on the left, and I am sure that if you will see this lady she will give you a lot more information about it. Now, I want to - while we are thinking in these terms - think of some organizations through which it can be effective. We can't pass a law and say there will be better health in all communities. That just can't be done. I want, as we start over here, just to name some organizations that you have in your community. What organizations do you have? Well, I will start with the church - every community has got a church and a school. What else do we have?

FROM THE AUDIENCE: Home Demonstration Clubs.

DR. WASHBURN: Home Demonstration Clubs. Now what else?

FROM THE AUDIENCE: Red Cross.

DR. WASHBURN: Red Cross.

FROM THE AUDIENCE: Civic Clubs, 4-H, P.T.A.; Tuberculosis Association, Heart Association, Cancer Society, Kuritan Club.

DR. WASHBURN: Anybody think of some more? There are a whole lot of them, there are just literally hundreds of them. Now that's how it is going to be done, you will do it through your own local organization. You will either do as they have done in the mountain counties, organize the community or some of the other sections, or you will do it through your church, your civic club, your Grange, your Farm Bureau. You will do it through the P.T.A., fraternal organizations, these local clubs, then as you heard this morning, there are 100, I believe, state agencies in this state of North Carolina, over a hundred agencies that are willing, ready, anxious, and actually being paid to do the job. Now one of the ways that you can

help your community is to find out how to get this information. I think one of the best ways would be to write Mr. James T. Barnes, Executive Secretary of the State Medical Society for a list of some of those organizations, also about how to go about it. This one problem, for instance, just the simple problem of how do we get a doctor? Just start with him, find out what communities need doctors, where doctors are available from. Mr. Barnes, are you here? Mr. Barnes, how about just standing up here and let the people see you. Come right in and let the people see you - just write him a letter here at Raleigh, Executive Secretary, he can start you on the road and he would also probably refer your problem to Mrs. Annette Boutwell. Is she here? Mrs. Boutwell, come up where they can see you a little better, I want to tell them who you are. Mrs. Boutwell is the Health Education Consultant for the Rural Health Committee of the North Carolina Medical Society and she came to us just not too many months ago from Mississippi with a big experience there in rural health work and she probably knows more right now about how the pieces of this health pattern are coming together in North Carolina than any other one person in North Carolina, and she can help with letters of introduction, with liason to these organizations, and she is a person who could come to your community and help start on the problem for any project whether it is getting a doctor or doing any of the other things that you want to do. Thank you, Mrs. Boutwell.

Now, those are some things, I wonder if there is another question now. We have a question from our recreation man.

MR. RALPH ANDREWS: I just wanted to tell the good gentlemen that Boiling Springs, his home, has been in touch with us. We know that you want an indoor-outdoor pool. Phil Elliott, the President of that fine college, a wonderful person himself, did know about the North Carolina Recreation Commission and has been in touch with us.

DR. WASHBURN: Fine, fine. Well, we certainly are going to use it some more and I hope every community that possibly can improve its recreation program will do so. Now, how about some questions from any of these other gentlemen, anything else? We have five minutes. If you have got that burning question on your mind that you just must ask let's have it in five minutes. We have five minutes and then you will hear the summary of this great conference.

FROM AUDIENCE: Do we have a resolution committee?

DR. WASHBURN: Do we have a resolution committee? I'll ask the program chairman. Do we have a resolution committee?

DR. DAVIS: No, we do not have a resolution committee, but I am sure that if she will give her resolution to the Rural Health Committee that they will take this to the proper authorities.

DR. WASHBURN: Fine, thank you, Dr. Davis. Dr. Davis has answered that question for us. Any question about taking these fine suggestions home and doing something about them? If not, thank you, Mr. Hendricks, and we will turn the meeting over to you.

MR. HENDRICKS: We are certainly grateful to all of these who have so kindly taken their part and done it so well in the program. We are going to turn the meeting back over to our general chairman for the conference, Dr. Rachel Davis. It has been my observation that women preachers and women doctors are scarce in this country and I know all of us appreciate the work that Dr. Davis is doing as General Chairman of this conference, what she means to rural health in North Carolina. We will ask her to take the platform and the rest of us now will find our way, I am sure.

DR. DAVIS: Thank you. Well, we certainly wish to commend Mr. Hendricks and his group of cooperators on a very fine presentation of methods and means and systems of motivating people to do things together.

We will close by another speaker this afternoon, that we were reaching the day of specialization, and I think maybe subsciencely with the thinking about that when we chose the person to give long evaluation and complete resume of this program, Dr. Ouian Johnson, who is a Sociologist and a native of Chapel Hill, is going to give our resume and at this time we have Dr. Ouian Johnson, Dr. Johnson.

DR. JOHNSON: Thank you, Nineyears ago a slender boy of twelve on his first day of vacation from school went down to the mailbox and was struck by a near psychotic and seriously injured. Within twenty minutes of the accident he was receiving blood transfusions in an excellent hospital and after five hours of this treatment his broken bones and his terribly lacerated face were mended. Today, he is 21. A stranger looking at him could never tell that he had suffered such a serious accident involving among other things, the loss of eight front teeth. If that boy had been yours, would he have had immediate surgery, quick transfusions and the services of one of the best plastic surgeons in the south. If you live in one of those counties in North Carolina where there is no health center, where there is no health department, where there is no community development program, the chances are that your boy, had he suffered such an accident, would have been crippled for life, if he had not bled to death before he received medical service. We have heard of the great medical advances in North Carolina today. We have been told that life expectancy has been increased at least for white women, fourteen years within the last 25 years. But there are groups in our society that do not have this life expectancy increase. We have been told that some 85 per cent of our counties have some kind of rural health development program. We have been told that the farm income in North Carolina has rapidly increased within the last decade, but we have also been told that rural health, for the hope of all people, little intricate problems it has many complexities, it cannot be divorced from the

economics of the community. It cannot be divorced from agriculture, from industry, it cannot be divorced from education or from human motivation. The problems are as complex as the factors which enter into good health. It is a matter of sanitation, it is a matter of housing, diet, hutrition. It is a matter also, of the extension of the medical services which we do have the wide application of those health dollars which are now available. It is our problem, calling for greater health personnel, more nurses, more doctors, more dentists. When 50% of dental caries cannot be met for lack of dentists then something is wrong with health in North Carolina. What is the best approach. The best approach to the rural health problem in North Carolina as is the best approach to any health problem is through community organizations, many times the resources are available, but lacking,is the knowledge of these resources or the motivation to use them. Three years during the war, my husband and I were in Georgia; I suddenly found myself as the Executive Secretary of the Georgia Conference for Health and Welfare, and in that capacity I had the privilege of working in the organization of the Georgia Rural Health Conference and serving as a volunteer Executive Secretary of the Georgia Rural Health Conference. The Hill-Burton funds were just being made available. Almost no rural hospitals, just these nine years ago in rural Georgia, the doctors desperately wanted better hospital facilities and urged their wives to get to work in the Medical Auxiliary and in the women's olubs, and in the Home Demonstration Clubs to bring abou the passage of the Georgia Legislature of Hill-Burton matching funds. A group went to call upon Governor Arnold to see if his support might be had for pending legislation which would be introduced in the Legislature. When he looked the group over, and heard their request for his support, he said, "If you want better health in rural Georgia, you will have it," and then he turned to a Mrs. Brown, wife of a former president of the Georgia Medical Society and said, "Mrs. Brown, how many times did you come to see me when

you wanted good roads in Raven County?" She said, "Well, it seems to me I made twenty-five trips and brought a caravan of some fifty or more cars down during the session of the Legislature. Well, I think maybe it was three times." He said, "Well, all right, when you are as interested in good health as you were in good roads in Raven County, you will have good health in Georgia." North Carolina, I am delighted to say, has been interested in rural health for many, many years. Not long after this visit to Governor Arnold, Dr. Guy Lunchburg of our State Board of Health in Georgia, introduced me as being from North Carolina. "That state," he said, "which has set the finest example ever presented by any southern state. The moment you leave the borders of North Carolina you immediately see sanitation and good health deterinate rapidly until you get the the United State of Georgia." North Carolina has been concerned with rural health, but North Carolina concern, much as Dr. Washburn and many others have pointed out today, be multiplied by every citizen of North Carolina. We have met here and talked. We have been inspired and as Dr. Walker has said, "It has been like a revival meeting," but unless we are determined to leave this session convinced of our own responsibilities for good health we have done just so much busy work today. I hope you won't be as guilty as I in filling out my meeting reaction sheet saying what are you going to do for good health. I think that's given down here and I regret to say that I will be busily engaged in writing up a research problem and will not have the time to devote to health projects this year, and then after this afternoon's panel, I suddenly became converted. I am going back and have that periodical health check that I have been neglecting for the last eight months and I am going back and work on one of the home sanitation problems so acute in my county. What are you going to do? Are you going to be as interested in good health as you are in the condition of your automobile? What is your specific problem? Look again at your program - The Key To Good Health - is the community,

the individual, the agencies, but it is in your hand that will put the key into the door. I should like to underscore Dr. Davis' excellent summary of the morning session. Health is a community problem. It is not a purchasable commodity, but it is the produce of the cooperative effort of all of us to raise the health index of this state.

DR. DAVIS: Thank you, Dr. Johnson. That was magnificently done. Dr. Owens is the present President of the North Carolina Medical Society. Dr. Owens.

DR. OWENS: Thank you, Dr. Davis. From the Medical Society of the State of North Carolina, I bring you greetings. The improvement in rural health program is one of many worthwhile programs that your North Carolina State Medical Society has sponsored. We are especially interested in the Rural Health Program. We say to you our continuous support and cooperation. Dr. Davis, I wish to especially commend your committee for the excellent program. I wish to thank the various groups and organizations who have taken part in this program. I want to thank the people who have registered and attended this conference and helping to make it a success. When you go back home I want you to know that your State and County Medical Society are interested in your program. You may feel free to call on them for assistance and advice and participation. We have gained considerable success and the success we have already gained up to now, there should be a stimulus for us to go forward as a team, with aniticipation that in the very near future, we will have attained the goal of making North Carolina Number One in rural health in this great nation of ours.

DR. DAVIS: Thank you. Are there any other announcements from the floor? Governor Umpstead has declared this week from September 26 to October 2 as North Carolina Rural Health Week. A good many of the commissioners, Board of Commissioners, of various counties in North Carolina did the same. A good many of the rural communities have emphasized this week as Rural Health Week. If your county or

your communities did not participate in this, I wish you would, even if the week if half over, go back home and let your fellow citizens know that there is a great rural health movement on in North Carolina, and that this is the week in which we emphasize it, and that we would like for the movement to continue the year out. It has certainly been a wonderful experience to work with the group who have done so well, I think, on this program, of cooperating on this program, and it has been a wonderful experience to have the response from all of you who have attended. Now in order for you to have the procedures of this conference, and Mr. Hilliard has taken every word, it will be necessary for you to register, and make sure that you are registered out front, and if you are registered, you will be sent a copy of the proceedings of this conference and I think many worthwhile things have been said here today which we all need to try and go over and digest. Do you have an announcement, Mr. Barnes?

MR. BARNES: Referring to the evaluation sheets, again, Dr. Davis, be sure to get everybody aware of the importance of future conferences by filling them out. Because this conference is designed to meet the interest of the group.

DR. DAVIS: Thank you, Mr. Barnes. I think you all heard him, and you realize how much we depend on your opinion as expressed through these evaluation sheets.

Is there any other business. If not, we hereby declare that the Seventh Annual Rural Health Conference of North Carolina be closed.

THE END